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ABSTRACT

URBAN PLANNING AGENCIES ARE PRESENTLY PLAYING A ROLE IN PLANNING FOR COMMUNITY HEALTH SERVICES AND FACILITIES, AND COULD INCREASE THIS ROLE IN THE FUTURE. DATA GATHERED FROM PUBLISHED INFORMATION, QUESTIONNAIRES, AND FIELD STUDIES ARE USED TO: (1) DESCRIBE AND ANALYZE THE HEALTH SERVICE AND FACILITY PLANNING CURRENTLY BEING DONE BY URBAN PLANNING AGENCIES AND OFFERS A SERIES OF RECOMMENDATIONS DEMONSTRATING HOW HEALTH PLANNING CAN BE INTEGRATED MORE EFFECTIVELY INTO THE PROGRAMS OF URBAN PLANNING AGENCIES, (2) DESCRIBE AND ANALYZE THE WORKING RELATIONSHIPS THAT EXIST BETWEEN SELECTED URBAN PLANNING AGENCIES AND VARIOUS HEALTH PLANNING ORGANIZATIONS, OFFERING A SERIES OF RECOMMENDATIONS TO IMPROVE FUTURE RELATIONSHIPS, AND (3) PROVIDE BASIC INFORMATION ON THE MAJOR ISSUES IN HEALTH AND PROBLEMS OF HEALTH PLANNING TO AID URBAN PLANNING AGENCIES IN UNDERSTANDING THE MOST IMPORTANT ASPECTS OF COMMUNITY HEALTH SYSTEMS. (JK)

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a report by the
American Society
of
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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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PREFACE

This report is the result of a study undertaken by the staff of the American Society of Planning Officials under contract to the Public Health Service. It describes the present involvement of urban planning agencies in the health problems of their communities. It provides these agencies with an awareness of current health problems and suggests what steps to take in making their contribution towards the solving of these problems a more effective one.

It is traditional for urban planners to play a part in areas of transportation, recreation, residential, commercial, and industrial planning. However, as the report demonstrates, very few have been actively involved in health planning. Now, more than ever before, it is essential that planning for an urban area be integrated planning. It must be within the context of the societal factors which influence our lives, including, of course, the health factor.

This study then attempts to chart a more-constructive path for the urban planning agencies to follow in their quest towards a better society. And, while it is primarily directed towards these agencies, it should be of interest to all who are concerned with health, planning, and community development.

The report, completed in early 1968, was directed by Frank Beal, Principal Planner for the American Society of Planning Officials. It was supervised by Jerome Kaufman. Mary Ann Holohean and Gail Ornstein were the other ASPO staff members principally involved.

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Chapter I

INTRODUCTION

As the costs of health care continue to mount in the United States and as it becomes more difficult for individuals to receive the kind of care they need at the right time and place, it is becoming increasingly obvious that the health system cannot continue to develop in the chaotic, fragmented, and expensive fashion that has characterized its past growth. Comprehensive health planning programs are needed to offer solutions to some of the immediate and pressing problems now confronting the health system and to suggest ways for creating a more responsive and workable health system for the future.

During the past decade, interest in comprehensive health planning has grown tremendously. A new high was reached in November 1966 as a result of the enactment of Public Law 89–749, the Comprehensive Health Planning and Public Health Service Amendments of 1966 known also as the Partnership for Health Act. In passing this law, the President and Congress of the United States declared "that the fulfillment of our national purpose depends on promoting and assuring the highest level of health obtainable for every person, in an environment which contributes positively to healthful individual and family living * * *" To obtain this objective, it was recognized that a close cooperative effort would be required on the part of governmental, voluntary, and private organizations and agencies; and that it would be necessary to engage in comprehensive planning. To this end, Congress appropriated money to support the development of professionally staffed, statewide and areawide comprehensive health planning organizations. These organizations will be responsible for preparing comprehensive health plans, supplying information and advice to various public and private health organizations, and coordinating the planning activities of existing health planning bodies: mental health planning councils, areawide health facility planning agencies, health and welfare councils, and others.

The full impact of this important legislation is yet to be felt. However, its passage, coupled with the widespread support of planning by various health institutions and organizations, raises a question of major importance to urban planners: what role should urban planning play in the increasingly important field of comprehensive health service and facility planning? This question is the central concern of this report.

A LOOK AT THE RECORD

If the past is prologue to the future, it must be concluded that urban planners have, at most, a marginal role to play in community health service and facility planning. The research conducted for this study indicates that, in the past, urban planning agencies have given little time, thought, or effort to the identification or resolution of local health problems. For example, a questionnaire survey of 204 city, county, and regional planning agencies in 1966 revealed that 83 percent had spent less than 2 percent of their time on planning for health services and facilities during the preceding 2 years. Several agencies reported that they had done no health planning during that period, and over three-fourths of the agencies surveyed candidly admitted that health problems had not been adequately covered in their planning programs.

Further evidence of the meager attention given to health problems can be found by reviewing planning agency publications. Many planning agencies have prepared sophisticated special reports on the educational, recreational, or commercial needs of their communities; few have done comparable studies of the health needs of the populations they serve. A similar pattern is found in comprehensive plans, where entire chapters are devoted to work needs, shopping needs, living needs, recreational needs, and education needs—but not health needs. A review of 93 comprehensive plans completed since 1960 shows that in three out of every five there is no reference at all to health. Of the remaining plans, the sections on health are, in most cases, brief descriptions of the existing hospital system, with no attempt made to determine how well that system serves the needs of the public. In many communities, the zoning ordinance also reflects the planner's relative neglect of the health system. Some ordinances discriminate against medical uses that treat certain types of patients, i.e., mental or alcoholic, a practice that runs counter to the current thinking of health professionals and retards the development of a complete medical program. Zoning for medical facilities is often considered a nuisance to health personnel who see it as something to be overcome and to urban planners who are not certain about the ends to be achieved.

There are, of course, numerous possible explanations for the minimal attention given to community health problems by urban planners: lack of skilled staff to do the job; the private personal character of the health service system; the relative unimportance of health facilities as land users or traffic generators; and, probably most important, the historic resistance of the health field to the adoption of comprehensive planning approaches. These explanations, and others, will be examined in detail, but the essential point is that urban planners have shown little interest in health planning, have made few contributions to the improvement of health systems, and have not demonstrated a capacity or desire to undertake more ambitious projects in the future. If the past does dictate the future, then the case can rest here and there is no need for a study of the present and possible future interface between urban and health planning.

A brief look, however, at some of the major trends in the fields of urban planning and health and some of the major legislation of interest to urban planners suggests that health matters can and should occupy a more prominent place in the programs of urban planning agencies. It is likely that their past level of performance will not be adequate in the future. It will be difficult, if not impossible, for urban planners to ignore the fact that the provision of adequate health care is becoming an increasingly important problem of community life.

LEGISLATION

A substantial number of federal programs enacted during the last few years deal directly or indirectly with health and health-related problems. For this reason alone it becomes essential that urban planning agencies develop a better understanding of community health systems.

The Demonstration Cities and Metropolitan Development Act of 1966 (Public Law 89–754) is a good example of this legislative trend. The Model Neighborhoods program established by the act is an attempt to solve complex social and physical problems by concentrating a variety of public services and facilities in a single area. Urban planners have played major roles in drafting the several hundred program planning applications received by the Department of Housing and Urban Development, each one of which is designed to "make marked progress in reducing social and educational disadvantages, ill health, underemployment, and enforced idleness"; and to "provide educational, health and social services necessary to serve the poor and disadvantaged in the area." The process of making application has already served somewhat to orient urban planners to health problems, and in those cities which have received grants, urban planners will no doubt become further involved in local health issues.

Section 204 of title II of the same act provides for a different kind of participation in health matters. As of June 30, 1967, all applications for Federal loans and grants to assist in carrying out a variety of projects, including the construction of hospitals and other medical facilities, must be submitted for review to a regional planning agency that has been approved by HUD. Of potentially greater significance is section 205 of title II, which is not yet funded but which authorizes the Secretary of HUD to make supplementary grants for projects in those metropolitan areas that have a demonstrated capacity for carrying out a regional facility development program. This provision will provide an incentive for public bodies and individual Federal grant applicants—such as a medical service district or a hospital—to work closely with metropolitan planning agencies in developing regional capital improvement programs so as to qualify for the additional funds. Thus, title II gives metropolitan and regional planning agencies an important, although limited, means for influencing the development of a health facilities system.

The neighborhood Facilities program established by the Housing and Urban Development Act of 1965 is another example of legislation with a health service component. The purpose of the program is to establish multipurpose centers designed to offer concerted community health, recreation, and social services to low- and moderate-income residents. Many urban planning agencies participating in the development of these centers have been responsible for identifying areas of need, locating sites, and assisting in determining the proper level and types of services offered.

The 1965 and 1966 acts described here are but two examples of legislation that is, in effect, pushing urban planning agencies into the health field. There are other laws which have had a similar, but perhaps less direct, effect: The Hill-Burton Hospital and Medical Facilities Construction program, the Neighborhood Health Center program sponsored by the Office of Economic Opportunity, the Mental Health Centers program, Medicare, the Community Renewal program, the Regional Medical program, and many more. There is every reason to expect that future legislative enactments will require interdisciplinary approaches similar to that of the Demonstration Cities Act, as it becomes more apparent that the fragmented, categorical grant approach of previous years falls short of achieving desired results. The trend in legislation is clearly toward broader based, integrated attacks on urban problems including, whenever appropriate, a health service and facility component.

This trend raises the question of how well equipped urban planning agencies are to develop and carry out health-related plans and programs. What criteria, for example, should regional agencies use to review medical facility project applications? What is the appropriate location for a neighborhood health center, a mental health center, or a hospital: What are the barriers that keep the poor from receiving adequate health services? Is it because they cannot pay for services, or is it because the health service system cannot adjust to the unique life style of the poor? These are the kinds of questions that will increasingly confront urban planners as new legislation shapes their programs and broadens the range of their responsibilities to include the problems of community health.

THE CHANGING HEALTH FIELD

The inclusion of health components in major legislation is an important, but by no means the only, reason why urban planners are being drawn into health. The entire health system is in a state of flux, and many of the changes taking place have implications for urban planning agencies.

It should be recognized at the outset that the Nation's health care system is facing many serious and complex problems. The public vaguely senses that all is not right, and many health professionals are keenly aware of the need for reform. The National Advisory Commission on Health Manpower in its 1967 report to the President, stated the problems in terms of a paradox:

> On one hand, the numbers of physicians, hospital beds, and health services per person are generally equal to or greater than they were 30 years ago; research has vastly expanded medical knowledge; and the growth of private and public health insurance programs, along with Government support for the needy, have greatly reduced financial barriers to care. On the other hand, despite this apparently improved situation, there is widespread and serious talk of a health crisis in the country, a crisis which is believed to be upon us now or just around the corner. The indicators of such a crisis are evident to us as Commission members and private citizens: long delays to see a physician for routine care; lengthy periods spent in the well-named "waiting room," and then hurried and sometimes impersonal attention in a limited appointment time; difficulty in obtaining care on nights and weekends, except through hospital emergency rooms; unavailability of beds in one hospital while some beds are empty in another; reduction of hospital services because of the lack of nurses; needless duplication of certain sophisticated services in the same community; uneven distribution of care, as indicated by the health statistics of the rural poor, urban ghetto dwellers, migrant workers, and other minority groups, which occasionally resemble the health statistics of a developing country; obsolete hospitals in our major cities; costs rising sharply from levels that already prohibit care for some and create major financial burdens for many more.
>
> There is a crisis in American health care.[1]

The report states that the crisis will not necessarily be solved by placing more doctors, more hospitals, or more money into the present system, but that substantial progress will be made only if the system itself is restructured so as to meet the needs of the public better.

The entire health service system is coming under more frequent and more serious criticism as it becomes obvious that the process of receiving quality health care is, for most people, a long, time consuming, difficult, and expensive undertaking. The statistics show that many never find their way through the complexities of the health service system.

Problems of organization, financing, quality of care, and the unequal distribution of services are being discussed with increased frequency by Government officials, health professionals, and the public. Changes are occurring rapidly, more sweeping changes are being offered, and the health field is generally in a state of ferment. This general upheaval has already influenced, and will continue to influence, the possible roles that urban planners can play in health matters.

First, as a result of the crisis, health affairs are becoming more a matter of public concern. The notion that the public, either through voluntary associations or through government, deserves a voice in health affairs may be the handle urban planning agencies need to gain access to the highly fragmented, autonomous, essentially private health system.

Historically, the health system has been an essentially closed and private system. Health providers—the people who provide services—have identified the problems and organized the system the way they thought best. Now, it is being recognized that health consumers—the people who receive services—should also have a voice in restructuring the system. The trend is clear. The quality and quantity of health services is something that can and should be discussed openly and publicly, and by people who are not necessarily health professionals but who are generally concerned about the adequacy of the health service system. The climate is therefore, more receptive to the participation of urban planners.

A second trend is health that will ultimately have an impact on urban planning agencies has already been discussed: The health establshment's increasing use of planning methods. Planning is a relatively new term in the health field. Health professionals are not quite sure what it is or where it is taking them. They are asking some of the same questions that urban planners were asking (although not necessarily answering) 50 years ago: Does planning mean a loss of freedom? What is the relation of planning to politics? Does the planner set the goals or merely devise the means to attain the goals? It is reasonable to expect that those in health may seek the benefit of the urban planner's experience in the planning process?

Finally, at least some of the changes taking place in health today will require urban planners to alter their own programs and revise their thinking with respect to the configuration of the community health facilities system. The changes in the theory and practice of health care will make obsolete a great deal of the conventional wisdom urban planners held regarding the health system, forcing them to alter their thinking about how a health system can be accommodated within the larger community system. Zoning ordinances, for example, will have to be revised to reflect new philosophies of treatment and to incorporate new information on site development and location standards. The medical facility system is no longer simply a series of autonomous general hospitals, nursing homes, and doctors' offices, each with its own well-defined service area. The variety of facilities is increasing and the required relationships among them are becoming more complex. Consider, for example, the following trends which have important implications for transportation and land-use planning.

Health professionals agree that 25- or 50-bed hospitals are too small to be operated efficiently, and that 200 or 300 beds are probably a minimum acceptable size.

The large custodial mental institution is giving way to smaller mental health centers that must be integrated into the community.

The advantages of a medical center district in delivering quality health services are becoming more apparent. These districts will require a large amount of land and create major traffic generation problems.

While many services are clustering in medical centers, others are being decentralized as it becomes more apparent that accessibility to services is essential to receiving quality care.

There is a great increase in the number and variety of secondary health facilities, such as halfway houses for former drug addicts and alcoholics, mental health centers, rehabilitation centers, and extended care units. These uses have special characteristics that require special sites and locations.

General hospitals are tending to attract all manner of secondary uses, such as doctors' offices, pharmacies, outpatient clinics, and extended care units, but often the uses cannot be accommodated because the hospital is landlocked or because of excessively restrictive zoning provisions.

At one time, every medical facility was virtually an autonomous unit. Each had its own patient load, each competed for the best patients, each had its own source of financial support, and none knew or particularly cared what the others were doing. A variety of pressures is tending to make the health service pattern more complex; consequently, the need to view each facility as part of a total community treatment system is more apparent. Urban planning agencies appear to have an important role in accommodating the space and transportation demands of community health service systems.

THE CHANGES IN URBAN PLANNING

Changes taking place within the urban planning profession itself will also greatly influence the way in which planners relate to the health field. Never before have urban planners been so able or anxious to broaden their area of interest and to increase the extent of their responsibilities. The planning profession is currently in the process of evaluating and reevaluating its roles and purpose in community development. It has long been associated primarily with problems of land and facility development and, while this is the area of interest that continues to consume most of the time and resources of practicing planners, there are many who are questioning the desirability of maintaining this exclusive area of expertise.

Urban planners will recognize that Public Law 89–749 is not a unique or isolated event. Its passage is part of a larger trend toward the establishment of functional or special-interest planning groups which operate nationally, statewide, and locally. Increasingly, special-interest groups are adopting planning procedures as they recognize that the achievement of their objectives depends on a more rational allocation of their limited resources. The proliferation of these groups and the resultant problems of coordination and jurisdictional definitions is a major concern of all who are aware of the trend. It is certainly a concern of urban planners, who frequently find themselves trying to coordinate the work of these various groups or, more seriously, find new groups working in areas for which they have had some responsibility in the past. To put it bluntly, urban planners are being challenged by education planners, budget officers, recreation planners, and now health planners. They are being challenged to remain relevant to the changing demands and expectations of an exceedingly complex society. In the ensuing years, planning—what it is and what it does—will be debated and discussed even more than it is at present.

This report is, however, not designed to delve into problems of professional self-definition. The future growth and development of the urban planning profession will depend on the desires and the capacity of planners to accept new responsibilities, the willingness of legislators and others to entrust urban planners with new tasks, and a host of other variables. The point is, however, that because of the increase in the number of people adopting the planning title, or doing planning, urban planners are going through a period of intense questioning of their own aims and ambitions. They are, therefore, receptive to the idea of looking at their relationships with other planners—in this case, health planners.

PURPOSE OF THE REPORT

This brief review of some of the trends in health and urban planning suggests that a full examination of the interface between health planning and urban planning is in order. At present, the resources allocated to health problems by urban planning agencies appear to be less than adequate and will almost certainly be insufficient in the future if present trends continue. Although the potential contribution of urban planning agencies to the development of a community health service system may, in the final analysis, be small in comparison to the total health planning need, it is nonetheless important and does deserve careful examination.

This report describes the present and possible future role that urban planning agencies can play in planning for community health services and facilities.* It has three major purposes:

(1) To describe and analyze the health service and facility planning currently being done by urban planning agencies and to offer a series of recommendations demonstrating how health planning can be integrated more effectively into the programs of urban planning agencies.

(2) To describe and analyze the working relationships that exist between selected urban plan-

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*The study does not examine the role of urban planners in environmental health planning. It does recognize, however, that comprehensive health planning must include environmental planning as well as planning for the provision of personal health services.

ning agencies and various health planning organizations, offering a series of recommendations to improve the future relationships between these two types of organizations.

(3) To provide basic information on the major issues in health and problems of health planning in order to aid urban planning agencies in understanding the most important aspects of community health systems.

The scope of this report is exceptionally broad, ranging over considerable territory rather than focusing on a particular type of agency or a specific type of health planning problem. It is only a first step. Many subject areas are discussed only briefly although they clearly require considerably more investigation. The report is written mainly for practicing urban planners rather than for health planners, the planning profession, or the U.S. Public Health Service. It is expected, though, that these groups will find much of interest in the report. It is written with the assumption that urban planners know very little about health and health planning (an assumption verified by our investigations), and they, therefore, need to know some of the fundamentals about the health system and how health planning is organized.

The report, however, is not a manual of health planning explaining, for example, where a nursing home should be located, or how many hospital beds are needed in a community, or how to establish a patient referral system. It does not provide answers to health problems, but it does contain information on how health planning is organized and lists in the references and appendixes many of the basic sources of information on health planning. The report is a first reference for urban planning agencies rather than a how-to-do-it manual.

Most important, the approach of the report is pragmatic and cautious rather than bold and far reaching. It is an examination of what exists now and a discussion of what might exist tomorrow given the political, social, and economic realities of today. It recognizes that goals are already established, legislation passed, policies implemented, institutions operating with considerable historic momentum, budgets set, and professional associations committed in one direction or another. It recognizes that the entire health apparatus is highly resistant to change.

The point of departure for the report is today's urban planning agency with all its strengths and weaknesses, its limited budget, its overworked staff, and its present program commitments. The question is, how can these agencies best relate to the development of comprehensive community health planning, however it occurs.

As a result of this pragmatic approach, the conclusions are not surprising nor the recommendations bold. The fact is, urban planning is not essential to health planning. Individual health institutions will continue to develop and improve their services and facilities. Health planning organizations will be established and will operate no matter what urban planners say or do. The role of urban planning agencies is a role of choice; in most cases, it will be a supporting role. The agencies will be contributors to the health planning process, and in many cases important and essential contributors to it, but they will not be the principal force behind the health planning movement. With the exception of some important cases, no one has asked urban planners to be health planners, nor have urban planners asked to be included in the process. No one has yet given them the money or other resources to do the work that needs doing. Health planning is low on the list of priorities for most urban planning agencies, and it will probably remain low for the next few years.

It is true, of course, that under the provisions of the Comprehensive Health Planning Act, existing urban planning agencies can be designated as the comprehensive health planning body for the regions they serve. It is probable that a number of agencies will be so designated. Thus, urban planners will become health planners, and the problems of coordination will be intraorganizational rather than interorganizational. It is also probable that in many metropolitan areas of the country comprehensive health planning and metropolitan planning will be under the auspices of a council of governments. However, the majority of existing urban planning agencies—city, county, or regional—will not broaden their base to include comprehensive health planning. It is primarily to these agencies that the report is directed.

A more theoretical approach would have produced different conclusions. For example, the Congress could conceivably repeal Public Law 89–749 and in its place create truly comprehensive integrated planning offices throughout the country. It might do that in the future, but right now Public Law 89–749 is the law, and it does not build in the active and continued participation of urban planning agencies.

In the meantime, urban planners and health planners should take full advantage of the opportunities that are available to relate their respective programs. This report attempts to define those opportunities.

STUDY METHODOLOGY

Data for this study has been gathered from three primary sources: published information, questionnaires, and field studies.

During the early stages of the project, an extensive search was made for published information on health planning and for health reports prepared by planning agencies. Appendix A contains a selected bibliography of the most useful publications uncovered during this search.

Additional information was obtained through an extensive questionnaire sent to 259 city, county, and regional planning agencies. These agencies were selected on the basis of population served and size of the professional staff. Data from the 204 usable questionnaires returned is used throughout the report.

More detailed information for the project was gathered through a series of field studies. The project staff spent from 2 days to a week in each of five metropolitan areas interviewing urban planners and health planners, observing how they have worked together in the past and how they might improve their working relationships in the future.

The report is divided into four major sections. Chapter II is an exposition of the current state of community health planning. It is designed to provide a synoptic view of the organization of health services in this country, some of the problems associated with the delivery of health services, and the functions and character of community health planning organizations.

Chapter III contains a description of how urban planning agencies are currently contributing to community health planning efforts and a discussion of the attitudes of urban planners toward increasing their participation in the future.

Chapter IV is an evaluation of the constraints that will retard the integration of urban planning and health planning. A series of recommendations directed to urban planners concerning their roles in community health planning is found in chapter V.

Chapter II

HEALTH CARE AND HEALTH PLANNING

The central thesis of this study is that urban planners can and should play supporting roles in community health planning. They will make important contributions, but these contributions will be subsidiary to the core concerns of the local health planning process: identification of health needs, establishment of health priorities, development and distribution of health resources, and implementation of health plans.[2] Urban planners will support health planners and contribute to an improved health planning process; they will not become health planners.

In order to play an effective supporting role, however, urban planners must understand more about health planning—who the health planners are and what they are trying to do. The value of their contribution will depend upon how well they understand the complexities of the health care system and the ways in which health planners are trying to alter that system. The purpose of the following discussion is to introduce the reader to what has loosely been defined as the health planning movement. It makes little sense, however, to talk of health planning without first understanding the context in which it came about. Since health planning has evolved in response to numerous health problems, it is necessary to begin with a description of the major issues and components of the community health care system.

HEALTH CARE: AN OVERVIEW

The word "system" is a convenient but inaccurate term when used to describe the structure and methods of financing and delivering health care services. It is inaccurate because it implies the existence of a finely balanced and harmonious organization of health care activities; in fact, health care is characterized by a multiplicity of poorly coordinated subsystems, many of which operate almost entirely independent of each other.[3]

Furthermore, there has never been nor will there ever be a single, "best" system of health care. The way in which personal health services and goods are organized, distributed, and financed depends on a multitude of factors outside the health care establishment. The best health care system is the one that most effectively uses its internal resources (manpower, knowledge, institutions, equipment, and organizations) to meet the external demands and expectations of society. Today, it is fairly evident that the Nation's health system has not been sufficiently responsive to the rapidly changing needs of an increasingly complex and affluent society.

The most prominent characteristic of the existing community health system is its complexity. The simple one-to-one relationship between a patient and a family doctor capable of delivering a complete package of medical services from his office is impossible to maintain in the face of the societal changes and medical advances that have taken place during the last several decades. New medical knowledge, the need for special equipment, the necessity for greater specialization, new patterns of disease, greater population mobility, greater public expectations, and an acceptance of the principle that everyone should have access to health services have made it impossible to maintain a simple system of health care. Instead, health services must be delivered by a complex grouping of people and institutions to a highly mobile and demanding society, and must be financed by an equally complex grouping of private individuals, governments, and insurance carriers.

This complexity and disorganization creates two major problems: (1) There are serious gaps in the distribution and quality of health care, and (2) there is an inefficient use of the system's limited resources. Broadly speaking, these problems define the central concerns of health planners: To create a system that is able to deliver quality health services to all people and to make maximum use of the available manpower, money, and facility resources.

Closing the gaps.—The gaps in the service system are serious; as a result the Nation's health ranks below many less affluent countries. For example, the number of countries where mortality rates are lower than in the United States has steadily increased in the last few decades. In terms of average remaining lifespan at age 10, our males rank 31st and our females rank 12th in the world. In other words, there are 31 countries in which a 10-year-old boy can expect to live longer than he can if he is a resident of the wealthiest Nation on earth.[4]

These relatively poor rankings can be explained, in part, by the unequal distribution of health services among the different segments of the population. The poor, the uneducated, the farm dwellers, and the members of minority groups simply do not receive the quality or quantity of health services—and therefore do not enjoy the level of health—received by members of the middle and and upper classes. National averages, then, are pulled down significantly by the poor health of the people at the low end of the scale. The United States is second to none in the quality of its health manpower, research, facilities, and equipment, but because it has trouble in delivering services to the people who need them, its overall health status suffers.

Some members of the health system are very much aware of the problem of organizing and distributing health services and are struggling to break down the barriers that make services inaccessible, unavailable, or unacceptable to large segments of the population. There is increasing discussion about the need for comprehensive health care, where each individual, no matter what his age, income, or other personal circumstances, has access to the full range of personal health services: health maintenance, prevention of disease where possible, diagnosis and treatment where disease exists, and rehabilitation at all stages of disease to prevent aftereffects.[5] It is important to note that the achievement of comprehensive health care for all people has less to do with medical science and technology than with the social, organizational and financial aspects of medicine.

Conserving resources.—The second problem, that of maximizing the effectiveness of available resources is, of course, not unique to health. Every social undertaking continually faces the problem of how to allocate its resources. It is, however, a particularly vexing problem in health because there is no central unit, such as a planning unit, that can view the system as a whole. Because of the lack of communication between the largely independent and autonomous parts of the system and, more important, because many of these parts have never clearly defined for themselves the groups they intend to serve nor how they intend to serve them, it is extremely difficult to relate public demands to the manpower, equipment, and facilities of the total health system. Too many of the units are going in too many directions, making it difficult to plan for the allocation of the total resources of the system.

Nonetheless, planning is needed. The costs of health care cannot be allowed to continue to rise when there is evidence of waste and duplication of effort. The public cannot be expected to accept passively increased hospital charges when they hear that a new hospital wing must stay closed because not enough nurses can be found, or that one hospital complains of overcrowding while another has numerous empty beds, or that each of several hospitals has purchased an expensive piece of X-ray equipment while the community demand is less than adequate for one machine. Reports such as these are heard frequently enough to be of concern to health consumers, who are beginning to ask the hospitals and other units of the health system to stop passing the costs of inefficiency onto the public.

Planning is already being done at many different levels to help close the gaps and increase the efficiency of the health system. It is clear, though, that these planning efforts will have to be doubled and redoubled if significant progress is to be made toward substantial improvements in the system.

An examination of the components of a community health care system can help to illuminate the reasons why so many people are unable to receive comprehensive health services and why the system is unable to make better use of its limited resources.

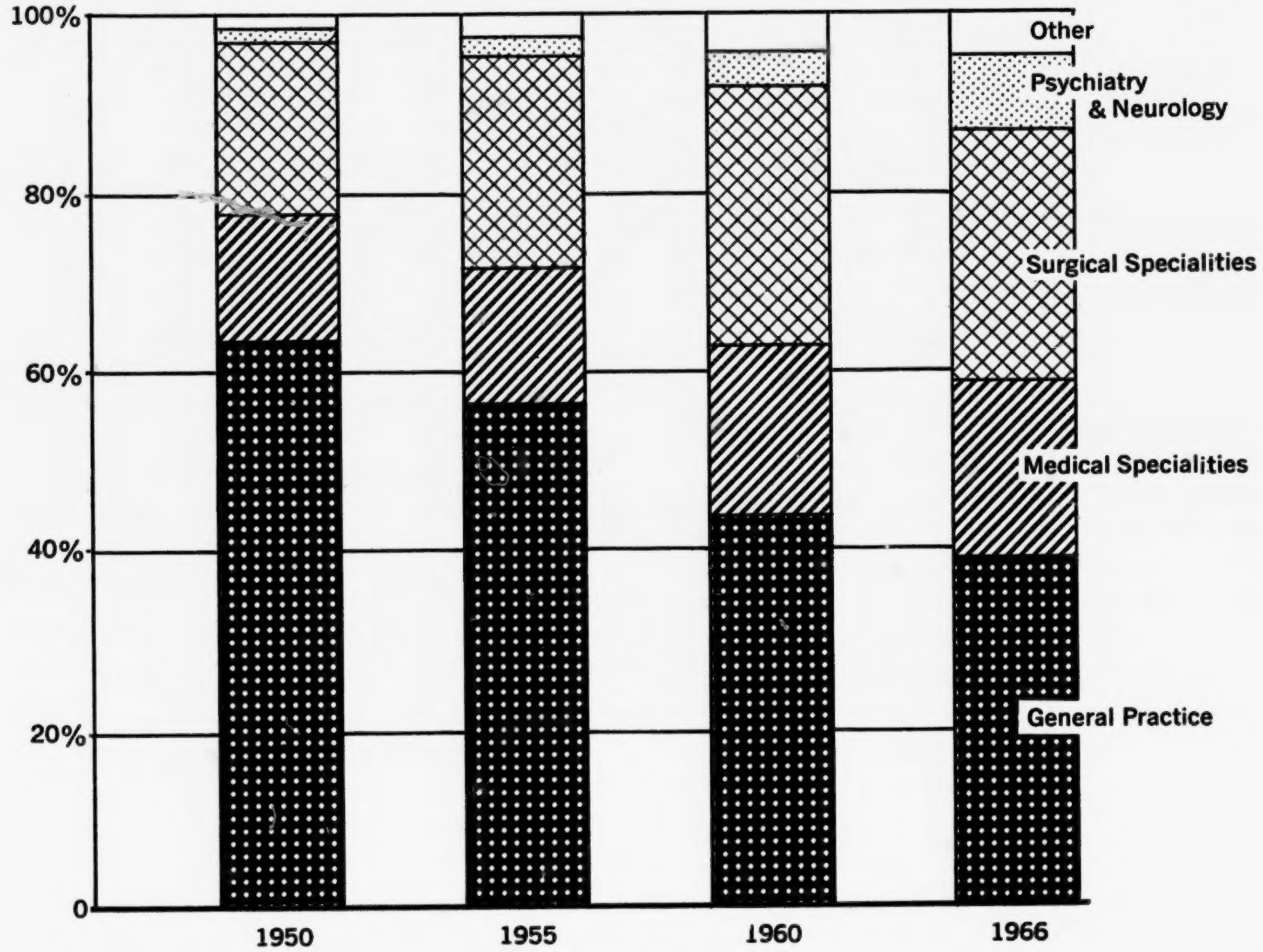
The Providers of Health Care

The doctor.—There has existed in this country a certain mystique about the doctor-patient relationship, a mystique which is a mixture of myth and reality. The classic ideal of an authoritarian but understanding physician who, without regard for the patient's ability to pay, provided total medical care to two and sometimes three generations of the family probably never was as prevalent as most people think. In any case, it is a relationship that cannot be successfully maintained in the face of changing patient demands and the tremendous expansion in medical knowledge.

Neither the doctor nor the patient is able, or perhaps even interested, in maintaining his side of that relationship. The modern doctor is a specialist; his services must be supplemented by the services of a host of supporting personnel. His black bag can no longer hold all the necessary equipment, just as his mind can no longer hold all the knowledge he needs. Because of the perennial shortage of doctors, he has to increase his productivity and, therefore, has little time for the more general concerns of the family doctor.

The average middle class patient today is better educated and has a higher income. He expects to pay for his medical services either directly, or indirectly through some form of insurance. He has just enough medical knowledge to question his doctor's advice. He knows he will probably move three, four, or more time during his lifetime. He is generally looking for the best professional service he can find, and he may seek the services of four, five, or more specialists to treat different members of his family or different illnesses. For the poor, the luxury of the "ideal family doctor" has never been and still is not a reality.

Figure 1. Specialization of Physicians in Private Practice



Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Manpower Source Book, Section 18: Manpower in the 1960's (Washington, D.C., 1964) p. 29.
The Upcoming Specialist Shortage, Medical Economics, Oct. 30, 1967, p. 69.

In light of these changes in both patient needs and medical practice, one would expect significant changes in the way patients receive services or in the way physicians extend them. Some changes have taken place in response to the altered conditions, but the fact remains that the predominant pattern of medical practice continues to be that of the private physician, based in an office he establishes and maintains himself. Thus, the physician operates as if he were an autonomous and comprehensive health service delivery unit, but his patient requires services from a vast range of specialized practitioners, equipment, and institutions. The whole patient must receive services from a fragmented service system.

Some doctors have, of course, taken a number of steps to cope with the increasing complexity of their field. At the most elementary level, for example, when one doctor refers his patient to another he is helping his patient function within the system. Also, medical arts buildings serve as something of a coordinating device even though the various physicians' offices are not organizationally linked.

One of the more important attempts to coordinate a number of specialties is the medical group practice, one definition of which is "four or more physicians working in collaborative practice for more than three years, and in which practice income is pooled and earnings are divided among the physicians on some prearranged agreement."[6] There are numerous variations of group practice. Groups may vary from three or four physicians to several hundred. Sometimes the practice is "owned" by one or a few physicians with others as employees. Sometimes all participants share equally in the management of the practice. Most groups operate on a fee-for-service basis, but a significant minority operate on a prepayment or health insurance principle where patients receive all the services they require for a fixed annual fee. The purpose of all the groups, however, is to make a wide range of services more conveniently accessible to patients.

Although group practice has many important advantages over individual practice, it has not been the panacea that many expected. First, the majority of doctors have not chosen to enter a group practice, and second, only the largest of the group practices are able to offer a broad enough range of services to make comprehensive care a reality for their patients.[7]

Health guides.—It is clear that the health system is so complex that patients need some kind of assistance in coping with it. They cannot be left to their own devices to seek out their own services, maintain their own medical records, and move from place to place within the system. The importance of having a health guide and a central contact point with the health system has been fully recognized by the National Commission on Community Health Services which recommends that—

> Every individual should have a personal physician who is the central point for integration and continuity of all medical and medically related services to his patient. Such a physician will emphasize the practice of preventive medicine, through his own efforts and in partnership with the health and social resources of the community.
>
> The physician should be aware of the many and varied social, emotional, and environmental factors that influence the health of his patient and his patient's family. He will either render, or direct the patient to, whatever services best suit his needs. His concern will be for the patient as a whole and his relationship with the patient must be a continuing one. In order to carry out his coordinating role, it is essential that all pertinent health information be channeled through him regardless of what institution, agency, or individual renders the service. He will have knowledge of the access to all health resources of the community—social, preventive, diagnostic, therapeutic, and rehabilitative—and will mobilize them for the patient.[8]

This suggestion does not require any reorganization of the service pattern, but instead relies on those who know and can function within the existing system. The problem, however, is finding or training enough doctors to do the job. In spite of the fact that the supply of physicians has risen slightly relative to the growth in population, it is increasingly difficult to obtain convenient and timely access to the personal services of a physician. He now spends more time with managerial, clerical, or other nonmedical responsibilities, or more time on hospital based activities, and therefore has less time to see patients. He is responsible for, and directs, many more services—his productivity has increased—but he does not personally deliver as many services as he once did. Furthermore, less than 2 percent of today's medical graduates go into general practice, and the general practitioners are the ones who would most likely be able to serve as health guides.[9]

The shortage of available doctors has led some health professionals to suggest that it is not possible or even necessary to have this function performed by a physician. They recommend that this task be given to specially trained health aides or nurses who can act as the initial and central contact points in the system. For low income people who cannot afford the services of the personal physician, this may be the only reasonable short-term solution. The poorly educated and low income person desperately needs knowledge about where to go for services, how to fill out insurance forms, how to spot symptoms of illness, and even such basic things as how to read a thermometer.

Paramedical personnel.—The suggested use of health aides or other nonphysicians to serve as focal points of the system is consistent with the continuing increase in the number of ancillary health personnel working within the health system. Since the turn of the century, the rate of growth in paramedical and supporting professions has been much larger than the growth rate for doctors. In 1900, for every 100 physicians there were only 60 health professionals, such as nurses, dentists, pharmacists, etc.; by 1960, there were 371 for each 100 physicians (see fig. 2). Today, effective comprehensive care requires that a physician use the services of dietitians, psychologists, social workers, statisticians, therapists, nurses, laboratory technicians, X-ray specialists, and many others. The ability of these various health workers to work for, and with, a physician will in great measure determine the extent to which quality health care will be available to all the public.

A continuing national problem is the shortage of health personnel of all kinds, and the effective use of the available personnel is perhaps the most important immediate issue confronting the health field today. It is now fairly evident that major progress in the manpower field will in the long run depend on breaking the health care task into its component parts according to the skills needed to do each particular task. Only if it is possible to break away from the traditional method of looking at the doctor and his patient, and subsequently to introduce greater degrees of personnel flexibility and mobility into the scheme so that paramedical personnel can be trained to do some of the jobs normally done by doctors and nurses, will it be possible to alleviate some of the more serious health manpower shortages.

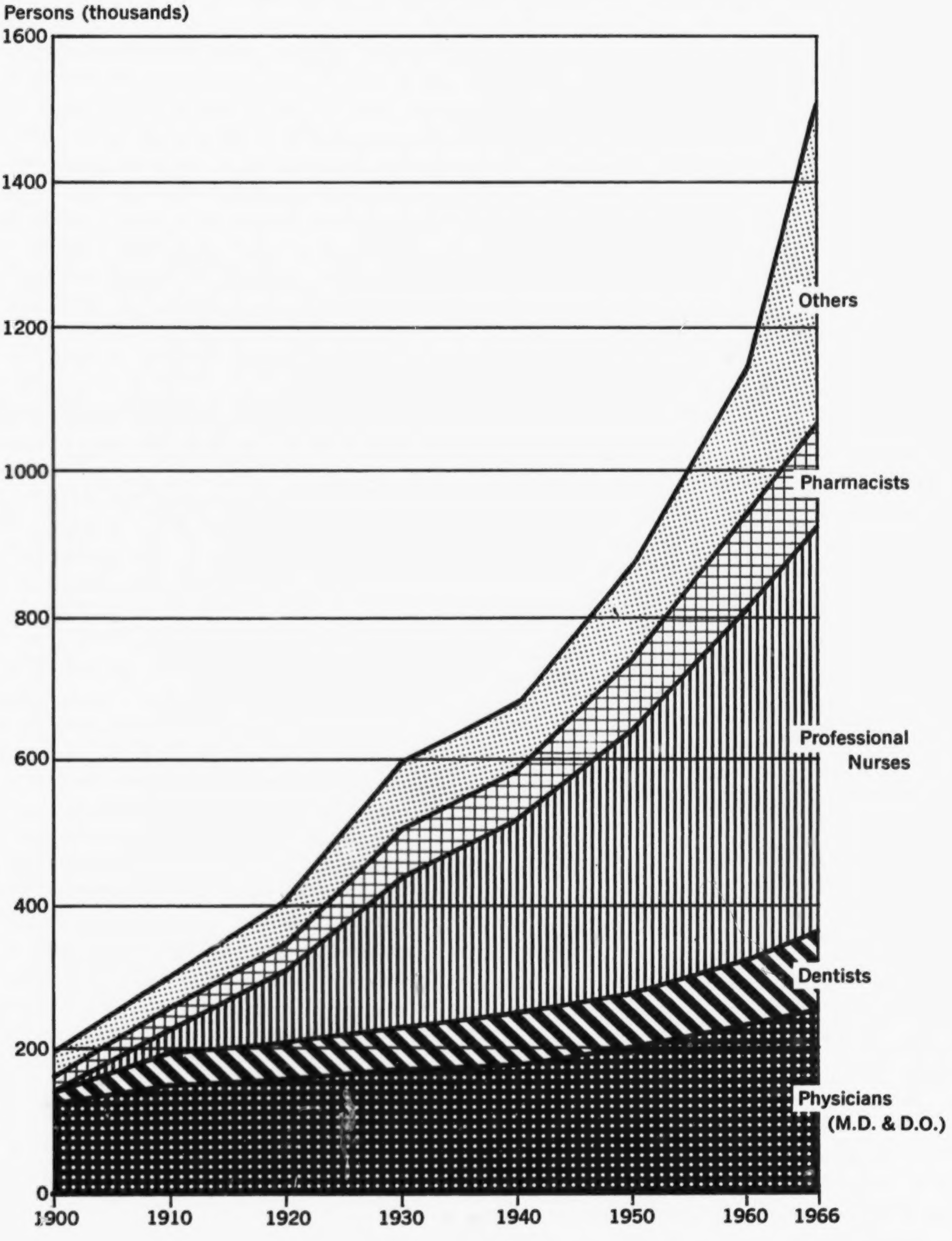
Some of the problems of the health system are apparent even at the primary level of contact between the patient and the people who provide the services. The providers of care have not organized themselves in a manner that is responsive to the needs of the average middle class patient and, as the statistics show, they certainly have not been able to respond to the critical medical needs of the disadvantaged segments of society.[11] Meeting the needs of all people requires new organizations and new concepts of service, e.g., neighborhood health centers for ghetto areas. That these new forms are slow to be developed is partly an indictment of the medical profession which has tended to support old practices long after their usefulness has expired. The attitude of most medical societies toward group practice has, for example, only recently changed from one of bitter opposition to one of at least limited support, despite the fact that the evidence suggests that group practice is more effective than private practice in delivering quality medical care. The fact that the group practices were established at a time when they were opposed by the American Medical Association, as well as the passage of Medicare over strong AMA opposition illustrates the lessening influence of organized medicine in shaping the patterns of medical care. However, anyone involved in health planning, whether health planners or urban planners, would be foolish to discount the considerable influence of medical societies. The attitude of private medicine is of utmost importance in organizing community health programs, since the participation of private doctors, who are the principal providers of medical care, is essential to their success.

To place the responsibility for progress in developing better delivery systems entirely on doctors or other members of the health professions is to disregard the fact that the form of medical practice is in part shaped by the demands of consumers. Although health care, as we shall discuss later, does not respond to an ordinary supply and demand market situation, public demand can be and is a useful instrument of change. At this point, the medical profession has not offered workable solutions to the increasing complexity of health care, nor has the public demanded acceptable alternatives. Public interest in health problems and their solution has been stirred, however, and we can expect more, not less, pressure for improved patterns of service.

Voluntary Health Organizations

Voluntary health and welfare agencies have played an essential role in maintaining and improving national and community health services.

Figure 2. Growth of Selected Health Professions



Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Manpower Source Book, Section 18: Manpower in the 1960's (Washington, D.C., 1964) p. 17.
U.S. Department of Labor, Bureau of Labor Statistics, Report #323, Health Manpower 1966–75 (Washington, D.C., June 1967) pp. 6–7.

These nongovernmental, self-governing organizations, supported primarily by contributions or dues, have become an important mechanism for private collective action. Their past contributions to the improvement of health are undeniable, and, although there is need for self-examination and reevaluation on the part of voluntary agencies, there is little doubt that they will continue to exert powerful influence in the health field.

There are currently more than 100,000 National, State, and local voluntary, nonreligious, health and welfare organizations which solicit general public support and which are responsible for a broad range of activities and functions. These agencies are the beneficiaries of about $2½ billion in annual voluntary contributions. Although not all of the 100,000 are directly concerned with health, most of them are at least concerned with the social and economic consequences of health problems.[12]

The major purposes of these organizations vary considerably. Some, such as the American Cancer Society, were founded to combat a specific disease. Others, like the Heart Association, are interested in a specific organ or function. Still others, such as the Mental Health Association and the Maternity Center Association, promote the health of special interests. The National Safety Council is an example of those organizations interested in a specific phase of health. Others, such as the Visiting Nurses Association, provide certain types of direct services rather than dealing with certain health problems. Finally, there are numerous professional organizations which primarily serve their members but which also promote health programs, encourage or sponsor research, and engage in health education activities. An example is the American Nurses Association.

Functions.—Although the functions of voluntary agencies vary with time and circumstances, they can be classified under these general categories: testing and demonstrating to official public agencies and organized medical groups the virtues of new ideas or techniques; educating professional groups and the general public; supporting research on the causes of health problems and methods of treatment; providing direct services, such as volunteer home care services, furnishing transportation to clinics, preparing bandages, and so on; and acting as critics or supporters of the activities of official public health agencies.

Like every other sector of the health system, voluntary health organizations are faced with new challenges and new criticisms from many sources. Many people have been highly critical of the inability of voluntary organizations to terminate, modify, or consolidate their programs to meet changing demands. In any metropolitan area there may be 100 or more autonomous voluntary agencies, each competing for essentially the same financial and manpower resources, and in some cases competing with each other to serve a particular group of patients. This proliferation leads to numerous gaps and overlaps in the total program. For example, it is not uncommon to find that there are several places in the community where the poor can have heart surgery but no place where they can have their teeth fixed; or, that there are a number of groups offering services to blind children but no groups serving the sightless adult population; or, that there are several groups offering partial services to the deaf which could offer far better and more comprehensive services at a lower cost if they would only consolidate their efforts. Some programs serve no real purpose, or cost far more than they yield in services, or compete directly with other public or private programs. In other cases, modest programs need to be increased substantially but there is no one able or willing to make the necessary adjustments. Health and welfare councils have attempted to exert a coordinating influence, but the success of their efforts has varied considerably. Many councils have acted as a central service agency, offering general advice and assistance to member organizations, but have done little to view total health needs in relation to available resources. The result is that there is often a fragmented voluntary program in place of a unified one.

Another problem of concern to voluntary organizations is the rapid growth of government participation in health activities. Although voluntary support for health programs has increased greatly in the last two decades, Government spending has grown even more rapidly. The problem is particularly evident in health research where, from 1940 to 1961, the Federal Government's share of medical research support went from 7 to 55 percent of the total amount expended.

In recent years, many voluntary agency spokesmen have addressed themselves to the growing influence of government and the corresponding threat to volunteerism. The question they pose is, "Is there a future for voluntary agencies?" While the answer is usually an optimistic "yes," the speakers recognize that the future of voluntary agencies depends on their capacity to alter their activities and their organization so as to complement public health programs rather than compete with them.

Voluntary agencies will undoubtedly continue to play an important role in health. Their independence and responsiveness are valuable for maintaining effective community health programs. However, the tendency of some segments of the voluntary movement to compete with each other and with public health is clearly antithetical to the achievement of a coordinated, comprehensive system of health services. Just as the individual medical practitioner is faced with a new role, so the individual voluntary agency is confronted with the necessity of altering its own course in order to remain relevant.

Public Health Organizations

The concept of public health has been evolving for several decades. Early definitions restricted public health to sanitation problems that had to be handled on a communal basis. Public health was also responsible for the residual functions that were not performed by the voluntary health organizations or private organized medicine. Subsequent definitions have expanded the concept until it now encompasses all aspects of societal and individual health and well-being:

> Public health is dedicated to the common attainment of the highest level of physical, mental, and social well-being and longevity consistent with available knowledge and resources at a given time and place. It holds this goal as its contribution to the most effective total development and life of the individual and his society.[18]

Although the definition is broad, the actual practice of public health is unquestionably more limited. Old practices and ideas are still firmly entranched, and it has only been in recent years that there has been widespread acceptance of the idea that public health could or should expand beyond its essentially negative role and restrictive boundaries.

Traditionally, the general nature of the public responsibility for health has been defined under three categories:

(1) *The protection, preservation, and promotion of the health of the citizenry.*—Public health is concerned with the control of communicable disease, with research and services in areas such as heart disease and cancer, and in environmental health including sanitation and air and water pollution control.

(2) *The establishment of standards and regulations that affect health and medical care.*—Government agencies set minimum standards for water supplies, restaurant sanitation, hospitals, nursing homes, and industries which might pollute the air or water.

(3) *The provision of direct medical services to certain groups of people.*—Our system of hospitalization for the mentally ill or tuberculosis patients has traditionally been a direct responsibility of state governments. In addition, it is customary for government to provide direct medical services to persons who are economically dependent.

In addition to the above major concerns, government, particularly the Federal Government, is responsible for direct health services to such special groups as veterans, dependents of armed forces personnel, and American Indians. Also, the Federal Government is increasingly playing a supporting role in health by providing funds for the construction of health facilities and the training of personnel.

The organization of public health is exceedingly complex, and the administration of public health programs is such that it partially contributes to the fragmentation that often makes health care inaccessible or unavailable. All segments of public health have the same objective: to advance the public interest by maintaing and improving the health of all citizens. But as is the case with all complex organizations, agreement on general goals does not always guarantee agreement on methods or subgoals. Some public health agencies are pursuing policies that are diametrically opposed to the policies of other agencies. This may be due to to a general lack of communication, or it may be due to the fact that the different agencies have completely different views about what should be done.

At the Federal level, health activities are the direct responsibility of numerous administrations, bureaus, and agencies of the Department of Health, Education, and Welfare: the Social and Rehabilitation Service and the Public Health Service, which includes the National Institutes of Health, the Health Services and Mental Health Administration, and the Consumer Protection and Environmental Health Service. Many other Federal agencies contribute to the total public health effort: the Veterans Administration provides health services to veterans; the Department of Defense provides health services to the Armed Forces and their dependents; the Office of Economic Opportunity is supporting the establishment of neighborhood health centers, and the Departments of Housing and Urban Development, Agriculture, the Interior, and others, although playing smaller roles, still help to maintain and improve the Nation's health.[14]

At the State level, the agency with the broadest health responsibility is the State health department. Policy for these departments is usually established by a State board of health whose members are appointed by the Governor. The fragmentation of effort at the State level is not so obvious but it exists nonetheless. For example, in some States mental health programs are entirely separate from the rest of the State's health activities. In most States at least one or more segments of public health have achieved a degree of independence and autonomy. They pursue their own programs with a single-minded zeal without regard to how their activities relate to the total public health programs.

Locally, public health is the responsibility of city and county health departments and various multijurisdictional special districts concerned with problems such as air pollution or sewage disposal. Local health departments are generally responsible to the State and receive funds and are supervised by State health departments.

In brief, public health is a government function and as such shares all the weaknesses that characterize government today: A diffuse and fragmented organization, too little money, not enough staff, competing programs, illogical jurisdictional boundaries, categorical grants that tend to reinforce piecemeal solutions to complex problems, too much paper work, and so on. In these respects, public health is probably no worse, and certainly no better, than any other area of public endeavor. Urban planners will recognize in public health many of the same frustrations they feel in dealing with the Department of Housing and Urban Development, the Department of Transportation, State agencies, and the various local governments and special districts in their own area. The names, the legislative committees, the title numbers, and the functions are different, but the pattern is the same.

The solutions to many of the problems of public health, therefore, depend on the solution to the problems of government in general. However, they go beyond problems of structural reorganization, types of grant programs, larger budgets, and so forth, to the core problem of determining exactly what public health should be doing. Will it continue as an essentially negative function with emphasis on disease detection, environmental maintenance, mass inoculation programs, and so on, or will it evolve into a more positive force in which it acts as a public advocate to represent the total health interests of all people?[15]

In some respects, public health has been a conservative and cautious element of the total health system. It has lacked the crusading and innovative spirit of the voluntary movement, and has been content to pick up the residual duties that no one else wanted to perform. Recently, however, a number of factors have encouraged public health departments to broaden their perspectives. For example, under Medicare, major responsibilities for assuring that quality standards are met in hospitals, home health agencies, extended care facilities, and independent laboratories have been given to the U.S. Public Health Service and, as well as to State health departments. If used wisely, this function could give public health a much stronger voice in setting quality standards for medical care. Also, there is a growing recognition by health workers that their role in secondary prevention not only involves the screening of populations for the detection of disease, but the followup functions of referral and case holding necessary to forestall reoccurrence as well. Changes of this kind illustrate the possible dynamic role public health could play in providing comprehensive health care to all people. If government, particularly the Federal Government, were able to relinquish its piecemeal approach to health, it would be able to play an even more important role.

These gradual shifts in delegated functions and attitudes are important and are indicative of the trend toward ever-greater participation on the part of government in health. Although there are many who decry this trend, its inevitability is really a symptom of the growing acceptance of health care as a right rather than a privilege. If health care is to be accepted as a public right for every citizen, then it will be necessary for legislatures to define the right, for the courts to protect it, and for a public body to make the right available by either providing services directly or by checking to see that the private and voluntary sectors adequately fulfill their community obligations.

Health Facilities

An urban planner's initial contact with community health is likely to be with the system of health care facilities—the hospitals, nursing homes, medical arts buildings, and so forth. Each separate facility needs land, acts as a traffic generator, has an impact on neighboring uses, serves a particular population group or has a defined geographic service area, and must be related to the other components of the total health system. An urban planning agency can do much to contribute to the proper functioning of a system of facilities.

Each health facility is a contact point between a patient and a physician whose services are augmented by the services of other skilled people and by a range of technical equipment. Every community should have a balanced set of facilities which, taken together, offers a full range of comprehensive services, conveniently accessible to the recipients and providers of services, and structured so that patients can move from one kind of facility to another as the need arises. In most communities, there are serious gaps in the services provided by facilities, and there is also an excessive and expensive duplication of services. Patients and staff alike find that movement between one facility and another (both in an administrative and physical sense) may be difficult, if not impossible. Upon close examination, many communities find that they have many independent facilities rather than a total system made up of separate but related parts. Such waste and duplication of health facilities is all the more inexcusable when the need for public facilities and investments in other areas is so great.

In looking at the various patterns of ownership of health facilities, it is easy to understand why cooperation among institutions is difficult.

In any given metropolitan area, there are usually Federal, State, and local health institutions, a number of separate volutary institutions operated on a not-for-profit basis, and several proprietary institutions operating for profit. In most cases, they have not been required to cooperate with each other, nor have they voluntarily done so.

Classification by function is even more difficult than classification by ownership, as illustrated by this partial listing of health facilities that might be found in larger metropolitan areas:[16]

1. *Offices of physicians and dentists.*—These take three general forms: the office of the individual practitioner, shared offices of several practitioners, and offices of group-practice clinics. The larger group-practice clinics may include on their staffs graduate nurses, social workers, medical technicians, medical record librarians, physical therapists, and others.

2. *Medical school teaching hospital.*—This is the most complex of the group because it functions as a classroom and a laboratory for the medical school and for graduate clinical education, in addition to being a patient-care and a community-service facility.

3. *Urban or regional teaching hospital.*—These hospitals are not directly related to a medical school and differ from the medical school teaching hospital primarily in their more limited program objectives and their primary emphasis on patient care rather than on education or research.

4. *Community multiple-service hospital.*—These hospitals are commonly referred to as community general hospitals and are the most numerous of the short-term hospitals. In 1966, short-term community hospitals comprised 5,812 of the 7,160 hospitals in the United States. Its basic objective is to serve physicians on its medical staff in order to meet the more common health care needs of people who reside in its service area.

5. *Rural basic-service hospital.*—This category of hospital has been developed in more sparsely settled areas to provide a place to which physicians can refer patients who require the basic services and facilities found in a hospital. It is dependent on other hospitals for more expert and complex services. The original intent of the federal Hill-Burton program was to provide funds on a matching basis so that this class of hospital could be built in sparsely settled areas and attract physicians to practice in those areas.

6. *Children's hospitals.*—There are three general groupings of children's hospitals: those affiliated with medical schools, those equivalent to a pediatrics service department in a general hospital, and those established primarily to treat the special problems of children such as physical disability or emotional disturbance.

7. *Tuberculosis hospitals.*—These hospitals are organized to provide services for people with tu-

berculosis and allied pulmonary conditions. They include programs of restorative and rehabilitative services. The decline of new tuberculosis cases has caused the closing or conversion of many tuberculosis hospitals.

8. *Facilities for the mentally ill.*—Facilities for people suffering from mental illness include short-term diagnostic and treatment centers, long-term rehabilitative facilities, and custodial care units. New therapeutic techniques have reversed the trend toward increased numbers of hospitalized patients, and there is an increasing emphasis on facilities where personal health services for the mentally ill can be made available within the community. Currently, over 15 percent of the Nation's general hospitals now admit psychiatric patients for diagnosis and treatment.

9. *Chronic disease hospitals.*—These units place primary emphasis on the provision of services to patients with a variety of conditions requiring extended rehabilitative and restorative care. Due to the problems of financing such care, most chronic disease hospitals have been under governmental auspices.

10. *Extended care facilities.*—Extended care facilities include county homes, convalescent nursing homes, and homes for the aged. The 1965 Medicare legislation requires that extended care units must develop ties with a general hospital if they are to be eligible for Medicare assistance. This should help to bring such facilities into the mainstream of the community's health care system and to improve the range and quality of services offered by these institutions.

11. *Family health centers.*—These community-based clinics are often publicly sponsored and, although many provide services to anyone who desires them, attention is usually focused on the indigent or the medically indigent. Some clinics offer a full range of services and others have a special focus, such as mental health, alcoholism, prospective mothers, or physical disability.

12. *The half-way house.*—There is an increased emphasis today on half-way houses that can serve as a bridge from institutional care for those persons returning to community life. These facilities offer special advantages to those recovering from mental illnesses or chronic illnesses or such special problems as drug addiction.

The single most dramatic example of the changing structure of medical care is the modern hospital. As late as 1873, there were only 175 hospitals and related institutions in the United States, and these provided but 35,000 beds. In 1966, there were 7,160 hospitals of all types providing 1,700,000 beds.[17] Within this 100-year period, the hospital has evolved from basically a warehouse for the sick, infirm, and dying to a community resource offering a wide range of services—an institution trying to be a central organizing point for all community health activities.

A recent statement by the American Hospital Association reflects the aspirations, if not the reality, of today's modern hospital:

> The concept of the hospital as a collection of the necessary physical facilities and personnel to provide medical care within its building or set of buildings is no longer viable in today's medical care system. The hospital now must be an organizational as much as a physical creature, an organized arrangement of all medical resources necessary to bring the individual, wherever located, into contact with the skills of his physician and other members of the health care team.[18]

The modern hospital should perform four major functions: It should be a center for community health, including prevention of disease, care of ambulatory patients, and home care; it should be a workshop for the physician, which has been its traditional function; it should be an educational center; and it should be a center for medical research.

While it is true that a large number of people today tend to view the hospital, rather than the private medical office, as the place to get care quickly and competently, few general hospitals are either equipped or staffed to provide the comprehensive services reflected in the AHA statement. With only a few important exceptions, most have not broadened their perspectives beyond short-term, acute care for inpatients. Preventive medicine, ambulatory care, the problems of the chronically ill, research, and health education run a far second in the usual list of priorities.

If the National's hospitals expect to become the focal points of community health programs, they will have to increase their efforts toward the maintenance and improvement of the quality of services and toward the better utilization of resources. To do so will require improved internal management of individual facilities and a greater degree of cooperation and shared effort between facilities.

Many hospitals are experimenting with methods for increasing their internal efficiency. For example, one of the simplest methods of putting a hospital to better use is to put it on a 7-day, 24-hour-working basis. Although hospitals operate every day of the year, they are primarily custodial institutions on weekends and during the late evening hours. Many of the essential services are run on a standard 40-hour-a-week basis. Another improvement would be to have more testing done on an out-patient basis. The New York Governor's committee on hospital costs reported that, on any given day, at least 10 percent of the patients in general hospitals were not sick but were there for testing purposes. The difficulty of course, with having patients tested outside the hospital is that such tests are not covered under most insurance plans. They are covered, however, if the patient is admitted to the hospital.[19] At the other end of the illness cycle—the period of convalescence or rehabilitation—many patients remain too long in the hospital, using and paying for the full hospital care facilities, when they could continue treatment as an outpatient. Many hospitals have added self-care units where the patient cares for many of his own needs. Home-care programs operated by a hospital are also useful in cutting down on the use of expensive hospital beds by patients who do not need the full range of hospital services. Another innovation is "swing" beds, where beds are located so that they can be used for different purposes. In some hospitals, one section has patients in the halls while in another section half the beds are empty, simply because some beds can be used only for certain types of patients.

These techniques have been effective, but the basic problem continues to be the "almost total absence of economic incentives for efficiency or mechanisms that would force the inefficient to improve or go out of business."[20] The present system of hospitalization and financing neither penalizes the inefficient hospital nor rewards the efficient, innovative ones trying to keep costs down. Until a system of incentives is created (or until the Government requires certain changes in the administration and organization of hospitals), the upper limits on hospitals costs will continue to be "all the market will bear."

It is clear that hospitals cannot concern themselves only with the problems that occur within their own walls. They must begin to look at themselves as part of a total system. Traditionally, hospitals, like medical practice itself, has been an individual enterprise. The development of each institution was carried out in relative isolation from that of other facilities, resulting in wasteful duplication of services, buildings, and equipment. According to the National Commission on Community Health Services, this kind of waste has occurred in communities where—

> * * * competition between health facilities—their governing boards, professional staffs, and administrative staffs—and desire to promote individual health care facilities without consideration of the programs of other facilities, has obscured the objectives which have been established for the community's health care facilities system. While such a sense of competition or individualistic planning is often given credit for developing better programs and better facilities, it has also resulted in wasteful duplication in those areas where health care facilities have been overbuilt, where costly equipment has been duplicated without professional staff being able to direct its use, and where an adequate supply of patients is not available to justify the expense.[21]

To further inter-hospital cooperation, areawide hospital or health facility planning councils have been established in over 70 metropolitan areas (see the section on health planning for a more detailed discussion of health facility planning organizations). The primary objective of these voluntary councils has been to exercise direct or indirect control over hospital construction and expansion plans, as well as to encourage the area's hospitals to enter into cooperative agreements concerning staff, equipment, and services. Most of these relatively young councils have been reasonably effective and have probably managed to eliminate some of the wasteful duplication that exists in all community hospital systems. Their success, though, has depended on the willingness of hospitals to give up voluntarily some of their independence and autonomy in favor of more realistic cooperative efforts. How much of their independence the hospitals will sacrifice for the benefit of the patient remains to be seen.

There are many important efforts being made to solve both the internal and external problems of hospitals and other community facilities. Nonetheless, the patient still finds his encounters with the facilities system often disorganized, wasteful, frustrating, and, of course, expensive.

The Economics of Health

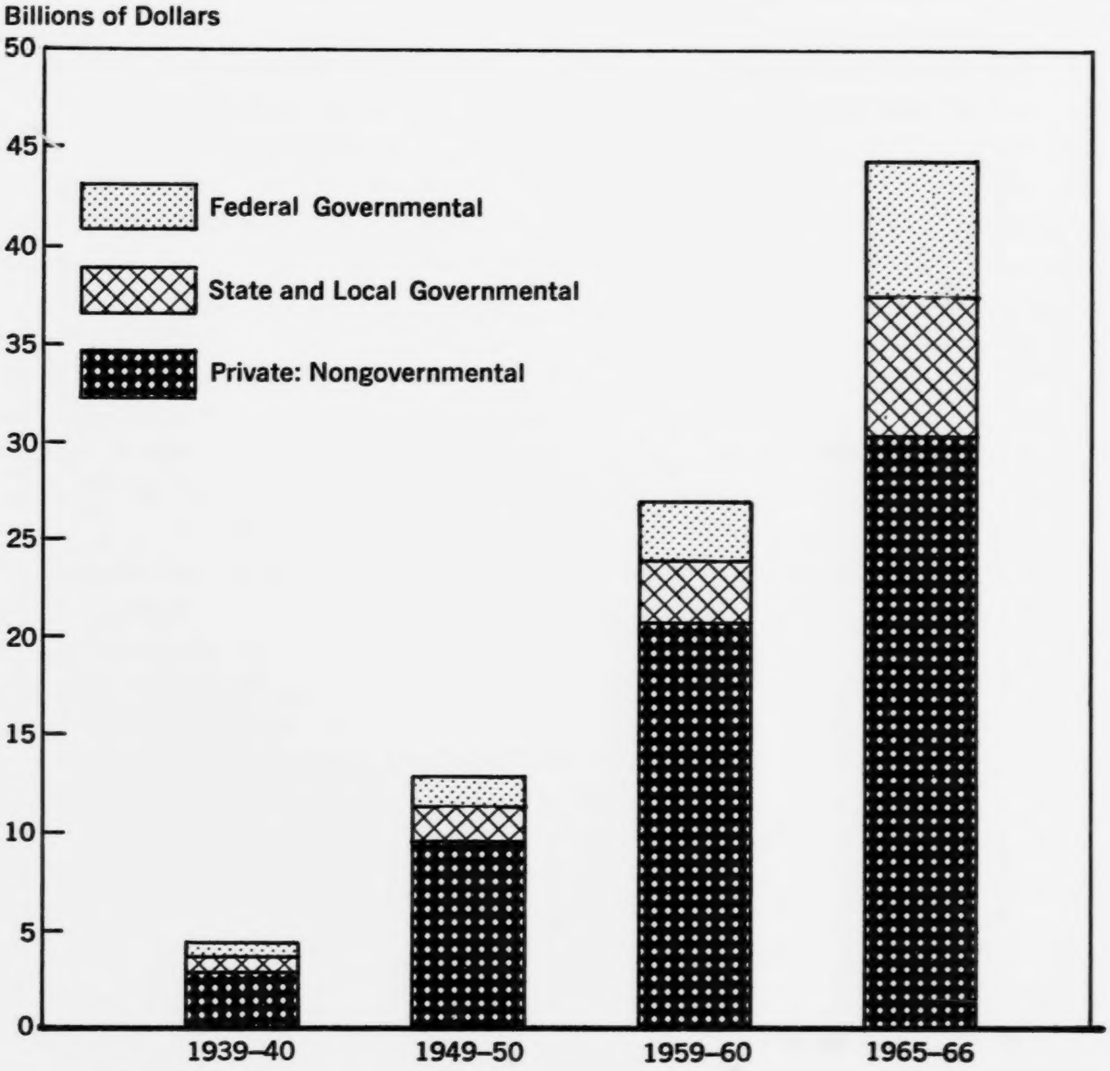
The rise in health care costs is well known and extensively documented. Statistics on the rapid increase in costs are a familiar feature of articles in popular magazines, Presidential task force reports, newspapers, and the reports of various professional organizations. Since World War II, the cost of medical care has risen over twice as fast as consumer costs generally; the total U.S. health care bill was $37 billion in 1965, 10 times what it was in 1929, and three times what it was in 1949; in 1950, consumer expenditures on medical care were 4.1 percent of disposably income and in 1964 they were 5.7 percent.[22] (See figure 3.)

The public, experiencing financial pressures from all sides, is becoming ever more concerned about figures such as these. More and more people in need of medical care are hard pressed to meet their payments whether they pay for such care directly, or indirectly through higher insurance premiums. In addition, the rising medical costs make Government-financed programs more costly for the taxpayer. As the public hears predictions of $100 a day hospital beds, they cannot help but wonder when and where it will stop.

Apart from the general inflationary trend characteristic of the whole economy, at present there are a number of factors that account for the steadily rising health care costs. The following are the most significant:

(1) *Changing population characteristics.*—Goups who use more health services are increasing in size relative to other groups. That is, urban people seek more health services than rural people; educated people more than uneducated people; high-income people more than low-income people; young children and old people more than the rest of the population. Since our population is expanding in these directions, there is bound to be a greater use of health services and, therefore, a greater average per capita cost of health care.

Figure 3. Private and Governmental Expenditures for Health and Medical Care: Selected Fiscal Years, 1939–1963



Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Chart Book of Basic Health Economic Data (Washington, D.C., 1964), p. 4.
U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, Note #3 Research and Statistics Note (Washington, D.C., Feb. 1, 1968), p. 142.

(2) *Higher wages for health personnel.*—Hospital wages, for example, which have been notoriously low for nurses, medical technicians, and maintenance personnel, are increasing rapidly and are pushing the total health bill upward.

(3) *Advances in medical technology.*—As new discoveries in medical technology are made, the demand for more sophisticated modern equipment and facilities increases. Consequently, health care becomes more costly.

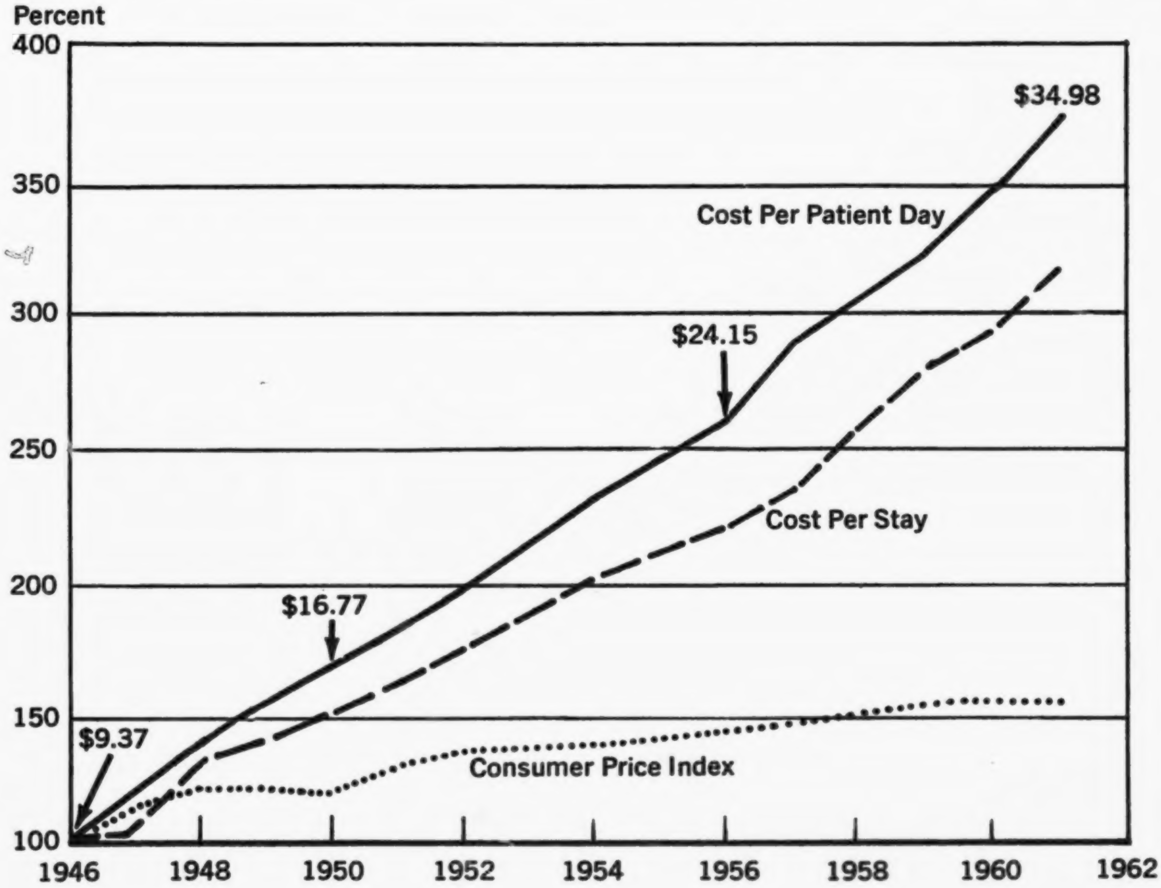
(4) *Greater use of health insurance.*—As greater numbers of people are covered by insurance, there is a general tendency toward the use of more medical services. More patients enter hospitals for treatment and tend to stay longer once they are admitted. Such increases are felt throughout the health care economy.

There are, therefore, two aspects to the growing size of the health bill. One is that the population seeks and receives more care, a trend largely independent of the price charged for services. On the other hand, doctors, hospitals, and the other segments of the health industry are charging more (because of more expensive equipment, higher wages, etc.) for each kind of patient contact. More demand and higher prices have combined to make the cost of good health a major item in every family budget. (See fig. 4.)

Much of the increase is inevitable and largely justifiable. Few would argue, for example, that medical costs should be kept down by eliminating the use of expensive X-ray equipment or by continuing to pay nurses substandard wages. However, the rate of increase has been so rapid that it is reasonable to ask where limits are going to be set, who is going to set them, and to what extent increasing costs have kept people from getting the care they need.

The limits on health care costs are particularly difficult to foresee because of the peculiar nature of health economics. Resource allocation decisions are not controlled by government nor are they controlled by the forces of supply and demand that operate in a normal market situation. The buying and selling of automobiles is simply not analogous to the buying and selling of health services. Many

Figure 4. Percent Rise in Hospital Costs for Short-term General and Other Special Hospitals, United States, 1946–1961



Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Chart Book of Basic Health Economics Data (Washington, D.C., 1964), p. 17.

other forces in addition to consumer decisions bear on the price, quantity, and quality of available services.

If, for example, public demand determined the number of physicians available, we would no doubt have far more physicians, or at least acceptable substitutes. The fact that there are not is a reflection of, among other things, the medical profession's historic desire and ability to keep its numbers low. Public demand also has little to do with the size of fees for medical services. A doctor is not an ordinary businessman, and the price of his product is not governed by the laws of supply and demand. There is little reason for a physician to price his services low to compete for patients, and if his services are expensive he will probably get patients anyway since: (1) A patient with an emergency medical problem has no choice but to get treatment; (2) even in nonemergency situations, the patient often regards medical care as essential, not optional; (3) the patient seeking medical care usually lacks information about the price of physician's services or assumes that the more expensive care is better care; (4) the patient is often referred from one physician to another without being given a choice.[23]

In the case of hospitals, it has already been pointed out that there are few incentives to keep cost down. In addition, health planners are now finding out what transportation planners have known for some time, that the construction of new facilities (a road or a new hospital) creates new demands. New hospital beds tend to be used, not necessarily because there is a need for them, but because the doctor finds it easier to treat his patient in the hospital, because the insurance will pay for it anyway so why not, and for many other questionable reasons. Up to a point, bed availability tends to operate like Parkinson's law: Physicians will use as many hospital beds as a community can supply. In any area, the minimum requirement for beds is usually obvious; at the other end of the scale lies a saturation point. The optimal number of beds needed, however, cannot be easily calculated by measuring need. Need varies greatly, depending on the acceptable alternatives (a home-care program for example), the judgment of doctors, the type of financing available (will Blue Cross pay for it or not?) and many other factors. Just as transportation planners are beginning to look for alternatives to building more highways and thus creating more highway users, health planners are now thinking more in terms of alternatives to hospitalization and, for that matter, alternatives to all the currently available treatment services and facilities.

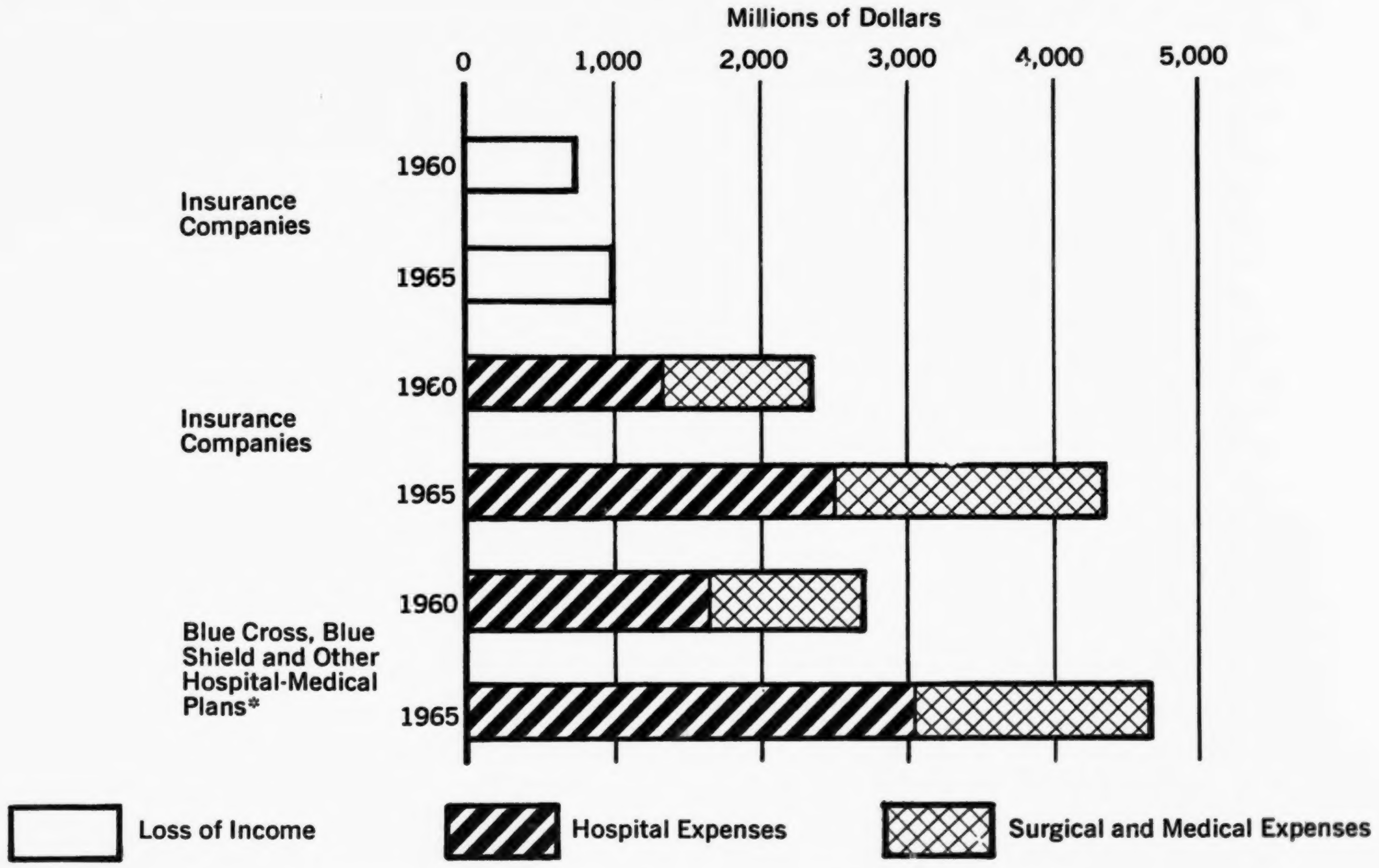
One of the major handicaps to reform in the health system has been that the financing has not been tied into an effective delivery system. The people who have paid for services whether individuals, insuring agents, or governments, have not used their purchasing dollars to press for reform. They have, by and large, paid for whatever services were offered in whatever manner they were offered, thus reinforcing and supporting the inefficiences within the system. This is changing somewhat, though, as evidenced by the reluctance of State insurance directors to approve new rate increases, and instead asking hospitals to increase their efforts to keep costs down.

One reason that there has not been greater public demand for reform is that the financial risks to individual consumers have been lightened as a result of the increase in public and private insurance programs. In 1965, over 80 percent of the American population had some form of health insurance protection through voluntary insuring organizations, including those insurance companies issuing health insurance policies as well as Blue Cross and Blue Shield plans and nearly 600 independent-type hospital insurance plans. Five major forms of insurance are available: hospital expense, surgical expense, regular medical expense, major medical expense, and loss of income protection.[24] (See fig. 5.)

Although health insurance has made the financial burden easier to bear, it has also contributed to the fragmented approach to health problems. There is a considerable need for more comprehensive types of insurance coverage to facilitate delivery of comprehensive care. Excessive reliance on insurance covering only hospital costs, for example, has resulted in excessive hospitalization for diagnosis and for ailments which could be dealt with on an ambulatory or outpatient basis. Also, many people are hospitalized in an expensive hospital bed not because they are seriously ill, but because the kind of insurance they carry makes this the most economical alternative. It has already been shown in some cases that broader insurance coverage can help cut down the excessive and unnecessary use of costly hospital facilities.[25]

The future prospects of health financing will undoubtedly be influenced by three major trends:

Figure 5. Health Insurance Benefit Payments: In the U.S. by Type of Insurer and by Type of Coverage, 1960 and 1965



* Includes payments by independent and Medical Society-approved or sponsored plans.

Source: Health Insurance Institute, 1966 Source Book of Health Insurance (New York, 1966), p. 42.

The continuing growth of governmental financing, especially at the Federal level; a greater emphasis upon more comprehensive insuring mechanisms; and a greater tendency of those who pay the bills, regardless of who they may be, to be more selective and critical about the services they are buying.

The increases in medical costs anticipated in the next few years would be far more acceptable to the public if it were certain they would be accompanied by proportionate increases in the quality of health care. It is not clear, however, that an acceleration in spending will automatically lead to better care; unless the system is reorganized it will certainly not lead to better health for the disadvantaged among the population. According to the National Advisory Commission on Health Manpower, "it may very well be that expenditures for other goods and services which influence health (such as environmental sanitation, better housing, and education) will improve health more than will comparable expenditures for medical services. It is, therefore, especially important to prevent inefficient and uncoordinated medical services from consuming resources that could be used for these other activities."

Summary

The negative element—the problems—have been purposely emphasized in this brief review of the health care system. The objective has been to emphasize and reemphasize that the health system is a vast, sprawling, complex collection of actors, institutions, and organizations that are often working at cross-purposes; that receiving quality health care is often a time consuming, difficult, and expensive undertaking; and that the system must be altered if it is to be at all responsive to the total health needs of the entire population.

If an urban planner is to contribute to the improvement of the community health system, he must guard against oversimplification. He must resist the temptation to look for simplistic formulas that will tell him how many hospital beds his town needs. He must be aware of the multiple interests in the health field, and be sensitive to their conflicting demands.

Finally, the emphasis on the negative aspects of health should not obscure the many excellent accomplishments of the health system. Health in this country is far from being moribund. The better hospitals are making impressive efforts to become comprehensive community care centers, groups of physicians throughout the country are experimenting with methods of reaching the poor, and the various governments are making greater efforts to fulfill their public responsibilities for seeing that all people receive quality health care. Certainly one important indication of the continued vitality of the health system is the growing interest and acceptance of the need for comprehensive health planning.

COMPREHENSIVE HEALTH PLANNING

Comprehensive community health planning is an opportunity—not a reality. Public Law 89-749, the Comprehensive Health Planning Act of 1966, is designed to make it a reality, but it will take many months or years before the potential of the legislation is realized.* This is not to suggest that there is no planning within the health field; in fact, a great deal of planning takes place locally, regionally, statewide, and nationally. This planning is, however, as multifaceted and fragmented as the health system itself. It has no focus, no overall direction; it is piecemeal, problem-centered planning, not comprehensive planning. The intent of Public Law 89-749 is to provide the focus and direction that is now lacking.

The dichotomy between existing health planning and the comprehensive health planning that everyone expects in the future makes it extremely difficult to define or describe health planning. Health personnel are operating under one structure while trying to shape another through means provided by Public Law 89-749. During this period of transition, much of their attention is focused on what will be, or what might be, rather than on what is.

Current Health Planning

The urban planner who seeks to identify "health planners" will find no easy answer. Few use the title. There is no professional association of health planners; only within the last two years have universities offered training for such planners. As difficult as it may be to identify urban planners, it is more difficult yet to identify their counterparts in health.

The relevant question then becomes: what organizations are likely to be engaged in health planning? Although there are numerous local groups involved either directly or peripherally in health matters, those most relevant to the urban planning agency include the areawide health facility planning council, the health and welfare council, and the public health department. By their actions and decisions, these groups are instrumental in shaping the character of the community health system. An understanding of their methods, concerns, and biases is fundamental to an understanding of the system.

Areawide health facility planning councils.—Health facility planning councils are voluntary, nonprofit associations whose primary purpose is to achieve economy through more effective use of health facilities and personnel. Currently, there are about 70 such councils operating in metropolitan areas throughout the country. The focus of most councils has been on the need, location, and timing of the construction of new health facilities, primarily hospitals. Most of them have made some attempt to survey existing facilities, chart utilization patterns, conduct patient-origin surveys, project future facility needs, and work out at least a rough plan for the future. Only the largest and the oldest, however, have delved into issues such as the determination of regional manpower needs or medical service requirements within institutions, the planning of extended care facilities, the problems of health education or the availability of services for the poor.

Most of the councils, while having no legal powers, are still able to regulate the flow of funds for health facility construction projects. One of their most powerful methods of control is to influence, through publicity and persuasion, the source of charitable contributions to hospitals. Banks and other lending institutions often ask a planning council's opinion before lending money for health facility construction, and additional influence comes from a close working relationship with the state agency that disperses Hill-Burton construction money. The official decision concerning grants is up to the state, but the Hill-Burton offices in many states rely heavily on the judgment of planning councils.

Critics of the voluntary planning councils have suggested that many of them are so much a part of the hospital establishment that they will never be able to do anything but make minor adjustments in the existing system. Their reliance on persuasion and occasional prodding will not, according to the critics, be sufficient to get hospitals to make the changes necessary to substantially improve the total system. This criticism is probably too strong since there is considerable evidence that councils have been able to eliminate some of the wasteful competitiveness that has so frequently characterized hospital growth in the past. It appears, however, that health facility planning councils have not really been able to decide whether they are spokesmen for the health interests of the general public. In most instances, they can play a dual role, but at times they are forced to decide whether they go with the public or with the hospitals. The inability of councils to clearly identify their clients has visibly handicapped their work.

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*See p. 28 for a discussion of the major provisions of the act.

The future of these councils, which are the most planning oriented of the various local health organizations, is open to question as a result of the enactment of Public Law 89–749. Some will broaden their range of interests beyond facilities to become the comprehensive health planning agency; others will remain separate and work with the comprehensive health planners.

Health and welfare councils. Because of their long history of coordinating community health and welfare activities, the more than 500 local health and welfare councils in the United States are important contributors to community health planning efforts. The primary aim of most health and welfare councils has been to improve the effectiveness of individual public and voluntary agencies by setting agency standards, improving working relationships between agencies, and providing information and other services to all their member organizations.

In the past, a relative absence of competition in the area of social planning allowed health and welfare councils to assume the role of the central community planning body for matters of social health and welfare. This period of dominance is clearly waning as other groups and other programs challenge the councils for leadership. The community mental health program, poverty program, manpower development training program, and many others often operate outside the direct sphere of influence of health and welfare councils. These programs constitute social planning subcenters with independent identities of their own. Their sponsors are often more concerned with political skills than with the consensus forming skills characteristic of councils. Their goal is change in the community structure rather than coordination of available resources, and many have little interest in the federated approach of the councils.[26] This intensification of an independent problem-centered approach to community dilemmas is forcing health and welfare councils to revise their own organizations in order to remain relevant to community needs.

In response to pressures of this kind, many councils have been shifting their emphasis from coordination and service functions to the more positive functions of identifying problems and shaping the community's response to them. The trend is away from an organization dominated by the interests of its member agencies to one in which major responsibility rests with lay leaders who have no stake in advancing the interests of any single organization or group of agencies. Problem-centered committees have replaced the traditional functional divisions of family and child welfare, recreation, and so on. The major benefits of this kind of organizational shift are increased flexibility of response to local need and fewer intermediate decisionmaking bodies between the council's working level and its board of directors.

Despite these shifts in focus, few councils are organized to do planning, whether health planning or any other kind. Most have a wide range of health institutions among their membership, and have exerted a coordinating influence on their activities. Many councils have done special studies of particular health problems, such as referral services for the aged or health manpower requirements; few have done any long-range comprehensive planning with the objective of revising the health system so as to more realistically relate health needs to health resources.[27]

Presently, many councils throughout the country are already actively participating in setting up comprehensive health planning organizations under the terms of Public Law 89–749. Whether they will be able to make a substantial contribution will depend on their ability to accept the advanced ideas concerning community planning that are inherent in the comprehensive health planning legislation.

Public health departments.—For most urban planners, the primary contact with the health system will be the local public health department. Urban planners often do work with health officers in environmental health programs and it would be natural to extend this relationship to include problems of personal health care. Although they do have the built-in social responsibility necessary for effective comprehensive health planning, the focus of public health departments on mass measures of disease prevention and their acceptance of residual functions has served to isolate them from the day-to-day problem of personal medical care. Furthermore, public health departments have had no history of a planning orientation. They are considered operating departments and as such have not felt the need to establish a planning capability. Nevertheless, the importance of public health in comprehensive health planning will grow, particularly in light of their expanding list of responsibilities.

Federal planning requirements.—In addition to the efforts of these local organizations, the Federal government encourages planning by making it a prerequisite to the support of State and community health programs. The Hill-Burton program and the Mental Retardation Health Facilities and Community Mental Health Centers Act of 1966, for example, require State plans. These plans clearly have an impact at the local level because they must be based on local needs and resources. Planning requirements are evident in most of the federally supported health programs and, while their value cannot be denied, it is intrinsically limited by the fact that they are all categorically inspired; that is, they deal with specific diseases, programs, or facilities rather than with the full range of health problems and resources.

Areawide health facility planning councils, health and welfare councils, public health departments and other local health organizations, plus the Federal program planning requirements form the base of current community health planning efforts. It is, admittedly, a weak base.

The most obvious problems are a diversity of interests and a lack of direction. At the moment, health planning, if it can even be called that, is a mirror image of the pluralism that characterizes the entire health system. Each organization and each Federal program concentrates on a particular set of problems. No group or program is focusing on the total health system. The lack of planning capability constitutes an additional problem. Some local health groups reject the planning label entirely, while others claim to be engaged in planning but know little about it.

Health planning stands where urban planning stood a half century ago during its "city beautiful" and "city efficient" stages. Considerable time is spent on selling the idea of planning and in getting organized to plan. Emphasis is placed on getting "influential" citizens on the policymaking board. It is thought of as a nongovernmental function as was urban planning during its early years, and much present thinking tends to be in the direction of embellishing the existing health system, making it more efficient but cutting down on costly duplications and smoothing out the rough edges, rather than advocating or initiating basic changes.

From the perspective of the urban planner, current health planning is still at the organizational stage, or, if organized, at the stage of survey and analysis or problem identification. Little policy formulation has been accomplished, programming resources to meet health targets is rare, and health programs or construction plans are often not related to previously agreed-upon and publicized health goals. In brief, current health planning efforts have not successfully met the challenge of the immense problems of the health system.

The Future: Comprehensive Health Planning?

There are four major reasons why there has been an acceleration of interest in comprehensive health planning during the last few years, an interest that has culminated in the passage of Public Law 89–749. First, many health professionals have accepted the fact that existing methods of solving health problems have not been successful. Piecemeal solutions imposed upon an already fragmented system have resulted in higher costs and little evidence of improved health care for the public. The traditional fragmented planning methods have not solved the twin problems of gaps in the delivery system and inefficient use of available resources. Second, more significant health legislation has been passed by Congress during the mid-1960's than in the previous two decades: Medicare and Medicaid; heart disease, cancer and stroke; OEO health centers, etc. It has become obvious that some mechanism is needed to properly integrate these relatively new programs with existing ones. Third, the public is growing more and more impatient, increasing their demands that something be done about the health system as they become more aware of the extent and seriousness of health problems. Fourth, what is happening in health is happening in other areas of public concern, such as education, recreation, and so on: Planning is becoming acceptable. For years, urban planners were the only ones who called themselves planners; this is cleary no longer the case as more and more specialists working in functional areas use the title—whether they be education, recreation, transportation, or social planners. To some extent, the health industry is jumping on the planning bandwagon, apparently with considerable enthusiasm.

Public Law 89-749.—The Comprehensive Health Planning Act is particularly significant for two reasons. First, it supports the establishment of state and regional agencies to undertake comprehensive planning for the whole gammut of health concerns—personal health services, health manpower, health facilities, and environmental health programs. Second, to a limited degree, it changes Federal policy from the categorical grant approach where money is given to a state agency for a specific health program, to a modified block grant approach so that individual States and localities will have more freedom and flexibility in using Federal money.

Under the law, the foundation of comprehensive health planning lies in the State office of comprehensive health planning. The Governor of each State may designate a single agency to conduct comprehensive health planning, either a unit created especially to do health planning in the Governor's office, an interdepartmental agency which represents various State agencies with major health responsibilities, the State planning department, or the State health department. Of the States that now have a designated agency, most have opted for the latter alternative. While this has the advantage of tying comprehensive health planning closely to the existing State health system, it may have the disadvantage of subjecting it to traditional prejudices and vested interests.

In order to introduce an outside point of view, each agency must have a State health planning council to advise it in conducting its health planning activities. A majority of the council members must be health consumers, persons who do not make their living by either administering health programs or providing health services.

The legislation recognizes that a variety of health-related planning functions (mental health planning, water resources planning, health facilities planning, etc.) are already being carried out by agencies on a statewide or areawide basis. It views the comprehensive health planning agency as a central coordinating body which may adopt portions of the plans of these other groups, or contract with other planning groups to contribute to the development of a State health plan. The comprehensive health planning agency will not, however, simply compile the work of others and act only in an umbrella capacity. It is expected to do more: Establish health policies and goals; identify problems; inventory available resources; produce a list of priorities and schedule of actions; and provide information and consultation to policy makers, the general public, and other public or voluntary health organizations. Each State agency must prepare and periodically revise a comprehensive State health plan. While the act does not endow the central planning agency with direct authority to carry out its plan, the agency that does its job well will unquestionably be influential in decisions concerning any allocation of health resources.

In addition to providing funds and support to State comprehensive health planning, Public Law 89-749 also supports the creation of comprehensive areawide health planning agencies, subject to the approval of the State health planning agency. Two kinds of grants are provided for comprehensive areawide health planning: one for organizational development, the other for supporting the activities of an approved organization.

In any region, there will be a number of groups that either want to be designated as the areawide health planning agency or at least have a strong opinion about who should be designated. In recognition of this fact, grants are available for periods up to 2 years to enable all interested parties to work together in developing a specific organizational mechanism for undertaking areawide comprehensive planning. Once this has been decided, the designated organization may apply for funds to support a comprehensive health planning program. Normally, the Federal share will not be greater than 50 percent of the project costs, but it may go as high as 75 percent under special circumstances.

It is possible that a local public health department, a health and welfare council, a local medical society, or any one of a number of public or nonprofit organizations may be designated the areawide health planning agency. Responsibility for comprehensive health planning could, in fact, be given to an existing metropolitan or regional planning agency. In the Washington, D.C., and Baltimore regions, it is probable that the regional planning bodies, which are both under the direction of councils of government, will be designated as the comprehensive health planning bodies. In large metropolitan areas or in areas where no agreement can be reached, it may be necessary to create a citizens' coordinating council with representatives from the major health planning groups of the area as the designated area-wide health planning organization. In many areas, because it will be difficult to agree upon a single body with responsibility for looking at the entire system of health care, many of the latent hostilities that exist between different segments of the total health system will undoubtedly be brought to the surface.

No matter what kind of organization is finally designated, it must include representation from the major public and voluntary organizations concerned with physical, mental, and environmental health, it must have a board or advisory council made up of a majority of health consumers, and it must have a full-time professional staff.

Like the State agency, the areawide planning agency is expected to perform a variety of functions: encourage individual institutions to initiate their own planning programs; establish a system for gathering and analyzing data; analyze the area's problems and resources; prepare plans for improving the health system, contribute to the State health planning effort; and review and comment upon local applications for grants and proposals for initiating or expanding health and health-related programs.

The legislation is still far too new to evaluate the work of State and areawide health planning agencies. Most States have a designated State agency, and a number of regions and metropolitan areas have applied for organizational or supporting grants. The next few years will be a period of experimentation to decide what organizational forms work best, what activities are the most productive, what planning methods are the most useful, and how this new comprehensive health planning program can relate to existing comprehensive urban planning programs.[28]

The Limits of Comprehensive Health Planning

There is currently a great deal of optimism concerning the potential of health planning. The possibility of greatly improving the quality of health care has generated enthusiasm in many different sectors of the health system, and with good reason. The comprehensive health planning legislation is progressive and holds great promise. It is hoped that this optimism and enthusiasm can be sustained, for there is much that can and should be done. There are, however, a number of difficult problems that must be dealt with if the full potential of comprehensive health planning is to be realized.

First, although there is widespread support for comprehensive health planning, the basis of this support varies considerably, depending on which interest group the spokesman represents. There are some who see health planning as the equivalent of self-policing, that is, as an opportunity to correct abuses before government sees fit to use its legal powers to make the needed adjustments. Others see planning in a completely different way—as the opening wedge toward more public control of a system. Still others are supporting planning because they see it as inevitable, reasoning that influencing it from within may be more effective than opposing it from without.

Second, although there are no strong objections to comprehensive health planning, there is a lack of consensus as to the purpose of it. Subsequent to the passage of Public Law 89–749, there has been much discussion concerning the objectives of a comprehensive health planning system. Beyond a few generalities, there are no clear statements concerning these objectives. It is not apparent whether the purpose should be to increase the productivity of the present system, minimize the social costs of illness, provide minimal levels of care to the entire population regardless of the cost, increase the amount of resources devoted to health, establish a new system of care, some combination of these, or something entirely different. It is, however, a measure of progress to know that at least the debate is focusing on the attainment of positive health objectives rather than on the more limited approach of increasing efficiency or eliminating waste and duplication. It is nonetheless clear that a sense of purpose is still lacking and it may be that national action will be required before this sense of purpose is evident.

Third, there is confusion concerning the methods of health planning. Health planners, or those who expect to be engaged in comprehensive health planning, have little understanding of the limits and possibilities of planning as an activity. In reviewing the concepts of planning held by health planners, one is likely to find everything from the simplest to very advanced ideas about the nature of planning. Unfortunately, most of these planning concepts have not been subjected to trial through experience.

At the most elementary level, there is the notion that planning is common sense, that it is inherent in every situation. This is true, of course, but hardly relevant as a guide for health planning. Those who hold this view, the practitioners, have adopted a community organization approach to planning. They spend their time getting people to sit down at the same table to discuss common current problems. Given the fact that there are instances in which hospital administrators in the same town have never met, or if they have met, adamantly refuse to talk to each other about their plans for the future, the community organization approach has considerable merit. The difficulty is that this kind of planning lacks direction. It rarely gets beyond solving immediate problems, and the solutions are usually minimal solutions, the kind that result from uneasy compromises between competing interest groups.

At the opposite extreme, some health planning theoreticians (not the practitioners) are advocating the use of a systems analysis approach to community health planning. They want to transfer the planning-programing-budgeting system approach and other management techniques that have been used in the development of space and defense systems to the health system. While this is no doubt a direction health planning might take, it is presently not a practical alternative for the community health planner faced with immediate problems. He does not understand the techniques well enough to apply them and, if he did, he would find that he had insufficient data to make the techniques workable. Furthermore, there is inherent danger in the techniques since they tend to force the user into narrow economic definitions of cost and benefit. In an affluent society, health priorities should be based on humanitarian reasons as much as economic ones.

Given time, health planners will develop a style and technique applicable to the situation in which they find themselves. Now, however, there is a considerable range of opinion concerning the methods of health planning. Current health planning practice has not been able to evolve satisfactory approaches to comprehensive health planning and planning theoreticians have not been able to develop a satisfactory alternative to the community organization approach.

Fourth, there is a serious shortage of qualified people to engage in health planning. Many who work in health planning are highly qualified in health, but have not been trained as health planners. They have an understanding of the health system but not of planning. They are, by trial and error, training themselves.

Recently, the U.S. Public Health Service has made the support of health planning education one of its high priority items, as they recognize that health planning agencies will not be effective unless they are staffed by qualified people who understand the complexities of the health field as well as the methods of instituting change. There are already a few interdisciplinary programs designed to train health planners, and there will probably be many more in the next few years. The Universities of Cincinnati, California, and North Carolina, and Cornell University all have prepared, or are now preparing, programs specifically designed to train health planners, combining the resources of urban planning departments with those schools of public health or hospital administration.

These programs present further evidence of the depth and extent of interest in health planning. Further, they bring to the surface many questions concerning the nature of planning education in this country as well as the character of the planning profession.

Finally, as presently conceived, comprehensive health planning has neither the capacity to move quickly nor the authority to see that plans are carried out and ideas acted upon. It is voluntary planning, in direct conformance with this country's accepted methods of problem solving. It relies on consensus, accommodation, compromise, and voluntary self-policing—and it is slow. Because it does conform with accepted national practices it is difficult to question the pattern that seems to be emerging, yet if it is true that a health crisis "is upon us now or just around the corner," we may not be able to afford the luxury of voluntary planning.

Will it be possible, for example, for voluntary planning groups with no sanctioning authority to convince insurance carriers to establish new payment schedules designed to force hospitals to upgrade their efficiency or close their doors, to convince doctors that they should be relicensed periodically and review each other's work, or to convince anyone that health care programs for the poor must receive the highest priority on any schedule of action? Is there enough time to allow health planners to win support and to obtain the voluntary commitments they need to make changes? If the emerging pattern is accepted, in the short-run the accomplishments of health planning organizations will be minimal. They have, after all, been created and nurtured by the health system and will at least temporarily accept the conventional practices that have guided the system in the past. Health planning will be slow to reject the biases of its parentage. Further, because they must constantly strive to accommodate the interests of so many different competing groups, health organizations will be unable to look much beyond the problems of conflict resolution. The obvious need for quick action and the inherent limitations of voluntary planning may necessitate a revision of attitudes toward strong control over certain aspects of the health system.

This is not to suggest that health planning organizations will not make important contributions to the health system; they will. They will establish data-sharing systems, help create referral service programs, aid in improving the accessibility of services to all people, participate in solving all manner of community health problems, and help make adjustments to what they consider a basically sound system. They will act as gadflies, as information sources, and as coordinators; they will point out problems, suggest solutions, and do much more.

At the same time, it is apparent that the more decisionmaking centers there are in a system the greater the need for planning, but the more difficult it is to plan. In health we see a system of planning that is relatively new, manned by people with relatively little experience in planning, suffering from a serious deficiency of data, lacking an action-oriented conceptual base, having no authority with which to carry out its plans, trying to cope with an exceptionally complex and emotion-charged social subsystem.

Despite the problems, and there are many, there is a momentum to health planning. There will be health planning agencies and there will be health planners. The biggest mistake an urban planning agency could make now is to underestimate the importance of health planning or to oversimplify the size and the complexity of the problems faced by health planners.

Chapter III

URBAN PLANNING AND HEALTH PLANNING: THE PRESENT RECORD

The preceding chapter has emphasized two primary points. First, serious problems confront the health service system of this country. Major changes are necessary in the way health care services are organized, financed, and delivered to the public. Second, in response to pressures to initiate change, the health field is moving rapidly to establish a system of health planning. Given this context, we return to the basic question: What role can urban planning agencies play in planning for community health services and facilities?

It is already apparent that there can be no simple answer to this question. Since health planning and urban planning are both in a state of flux, with their future development largely unknown, it is highly unlikely that a single satisfactory method will be found to integrate health and urban planning. More likely, the pattern will vary depending on the place, problems, and personalities involved. Indeed, there is a need for experimentation to determine what forms of relationships will work best.

To understand future possibilities, though, it is necessary to look at present modes of interaction existent between health organizations and urban planning agencies—to look at the various ways urban planning agencies have already contributed to the health planning process. This chapter summarizes the findings of the two phases of this study designed to assess the urban planner's present role in health planning: A questionnaire survey of urban planning agencies and field interviews with selected urban planners and health planners.

QUESTIONNAIRE FINDINGS

To determine what urban planners are doing in support of community health planning, a questionnaire was sent to 250 city, county, and multijurisdictional planning agencies in November 1966. The questionaire survey was designed with three purposes in mind: to document relationships between planning agencies and health planning organizations; to describe the substantive work in health planning being done by urban planning agencies; and to elicit the opinions of urban planners concerning their role in planning for health care services and facilities.

The questionnaire was distributed to a sample of the 700 public planning agencies which subscribe to the Planning Advisory Service of the American Society of Planning Officials. To discover the significant issues and trends in the relationships between health planners and urban planners, the sample was biased in favor of those agencies where the potential for cooperation with health planning groups was greatest: agencies serving large populations and agencies with large professional staffs. The results of the survey, therefore, do not describe the activities and opinions of the average urban planning agency, rather of selected agencies which, because of their size and staff, are most likely to be engaged in some type of health planning activity. If anyting, the data overstate the extent to which urban planners have been involved in health planning.

Two hundred and four of the 259 agencies (78.8 percent) returned questionnaires that were acceptable for tabulation. Table 1 shows the number of questionnaires received, by population and jurisdictional distribution. Since little significant variation was found between different population and jurisdictional groups, the results are discussed in terms of the totals for all 204 responding agencies. More detailed breakdowns of the data by population and jurisdiction are provided in appendix C.

TABLE 1.—*Population and jurisdictional distribution of agencies responding to questionnaire*

Population group	City agencies	County agencies	Combined agencies[1]	Total
Over 500,000	17	18	17	52
250,000 to 500,000	15	15	10	40
100,000 to 249,999	40	15	12	67
Under 100,000	40	5	0	45
Totals	112	53	39	204

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

TABLE 2.—*Planning agency involvement in planning for health services and facilities*

Extent of involvement	Number of agencies (n=204)	Percent of total
Percent of agency's time spent on health planning during past two years:		
Less than 2 percent	169	82.8
3 to 5 percent	30	14.7
6 to 15 percent	3	1.5
No response	2	1.0
Planning agency has been encouraged by health organizations to take a more active role in health planning	48	23.5
Planning agency's involvement in health planning has been, or would be, resisted by health organizations	38	18.7
Planning agency has staff members who are particularly interested in health planning	57	27.9
Planning agency has staff members who have had training and/or experience in health care planning	8	3.9

Participation in Health Planning

One of the most important findings of the survey is that urban planning agencies spend exceptionally little time on health planning problems. More than four-fifths of the reporting agencies say they spent less than 2 percent of their staff time on health service and facility planning during the period 1964–1966 (see table 2 and appendix tables 2 and 3). This means, for example, that a planning agency with a professional staff of five spent less than 5 man-weeks each year on health planning matters. All other responses to the questionnaire must be viewed in light of this fact.

There are some promising signs, however. Almost one-fourth of the responding agencies say they have been encouraged to play a more active part in health care planning by health and welfare councils, local health departments, areawide health facility planning councils, and other health planning organizations. Over 40 percent of the combined, or multijurisdictional, agencies report this kind of positive encouragement (see appendix table 2).

This optimistic sign is partially offset by the fact that 38 of the 204 agencies (18.7 percent) report that they actually have been discouraged from participating in community health planning programs, or thought they might be if they tried to move in that direction. A number of agencies comment on the importance of moving cautiously into health in order to avoid antagonizing the existing health organizations. A large city planning agency points out, for example, that "acceptance will depend to a large extent on how the planning agency defines its role in assisting the development of health facilities and services planning," while a small city agency says that "there would probably be some resistance unless the planning agency was invited to participate in this phase of planning."

One definite handicap facing the urban planning agency is its lack of staff trained or even interested in health problems. Only eight agencies report having staff members with training or experience in health care planning while 57 agencies, mostly the larger ones, have staff members who are particularly interested in the subject.

On the other hand, responding agencies identify 34 health organizations in their respective areas that have hired urban planners. This, no doubt, reflects the growing need of health planning organizations for people with planning experience. It appears that this crossing of employment boundaries is an aid to cooperative urban planning-health planning activities, since it facilitates communication between the two fields.

In general, the questionnaire survey reveals variation in the scope and depth of involvement in health matters. Some agencies have done nothing at all. Others have involved themselves sporadically in health affairs, and still others seem to have developed ongoing contacts with the more important health planning organizations. The fact remains, though, that no urban planning agency could have done much while spending less than 2 percent of its time on health planning.

Relationships With Health Organizations

The first objective of the survey was to describe the kinds of relationships between urban planning agencies and various health organizations, to see with whom urban planners were working and what they were doing.

The basis for interaction is visibility; that is, urban planners must first be aware of the kinds of health planning organizations operating within their areas. Table 3 lists all such organizations identified by the responding agencies as organizations which "operate within your planning jurisdiction" (see appendix tables 4 and 5). It is not a complete list. Probably all the 204 agencies should, for example, have checked "(*c*) State or county medical society," and "(*e*) State hospital and medical facilities agency." The fact that some did not mean either that they are unaware of the particular organization or that they are aware of it but have not had contact with it.*

The types of relationships urban planners have with the groups noted in table 3 vary considerably. Over one-fourth of the reporting agencies indicate that a member of the urban planning agency, either a commissioner or a staff member, serves on the board, commission, or a committee of one of the health organizations (see table 4 and appendix tables 6, 7, and 8). Most often, the planning agency representative serves on an areawide health facilities planning council or a health and welfare council.

Joint meetings between planning agency staff and staff members of health organizations are reported by almost 80 percent of the responding urban planning agencies. Staff meetings with an areawide health facilities planning council, a health and welfare council, or a local health department are reported by over half the responding agencies.

TABLE 3.—*Health organizations operating within the jurisdiction of the planning agency*

Health planning organizations	Number of agencies (n=204)
(*a*) Areawide hospital or health facilities planning council	127
(*b*) Health Council, health and welfare council, council of social agencies	148
(*c*) State or county medical society	156
(*d*) Local health department: City, county, or city-county	193
(*e*) State hospital and medical facilities agency (Hill-Burton agency)	118
(*f*) Local mental health planning council	113
(*g*) Other [1]	77

[1] Including State health departments or committees, individual hospitals and hospital boards, hospital associations, hospital districts or commissions, and county welfare boards.

TABLE 4.—*Organizational relationships between planning agencies and health planning organizations*

Organizational relationships	Number of agencies (n=204)	Percent of total
Planning agency member serves on board, commission, or committee of health organization	52	25.4
Planning agency staff members meet with staff of health organizations	162	79.0
Planning agency has technical advisory committee on health	20	9.8

Less than 10 percent of the reporting urban planning agencies have a technical advisory committee on health. Almost all planning agencies with such committees find them "very" or "somewhat" useful. In one community, the advisory committee provides standards for bed needs and statistics on existing conditions. Three agencies report that the committee makes recommendations on proposals for new health facilities or the expansion of older ones. One agency reports that, "the committee was especially helpful in advising the staff of the availability of a number of Federal health facilities programs which were appropriate for renewal and nonrenewal areas." A number of advisory committees help with problems of zoning for health facilities. The local health department and the areawide health facilities planning councils are represented on over half the technical advisory committees.

An important primary level of contact between urban planners and the health planning organizations is the sharing of information or data. As shown in table 5 (see appendix tables 9, 10, and 11), over three-fourths of the reporting agencies exchange publications and information of various kinds with the health planning groups located within their jurisdictions.

One hundred and fifty-nine agencies report that they send their publications to health organizations; 154 report that they receive health organization publications. In most cases, the planning agency sends publications of particular interest to the health organization rather than placing the

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*The number of planning agencies reporting an areawide health facilities planning council is greater than the total number of such councils throughout the country. Because the jurisdiction of a single health facilities planning council might encompass a metropolitan agency, a central city agency, and perhaps a county or suburban agency, some councils were checked by more than one urban planning agency, hence the larger total. This overlap also exists for other health organizations, such as health and welfare councils and mental health planning councils.

TABLE 5. *Exchange of information between planning agencies and health planning organizations*

Publications and data	Number of agencies (n=204)	Percent of total
Planning agency sends its publications to health organization(s)	159	77. 9
Health organizations send their publications to planning agency	154	75. 5
Planning agency requests data from health organization(s)	146	71. 6
Health organization(s) request data from planning agency	172	84. 0

organization on the agency's regular mailing list to receive all publications.

Over 70 percent of the urban planning agencies report they have requested data from one or more health organizations. Planning agencies request varied information on health care facilities: Inventories of health facilities, i.e., the location of facilities and number of beds; development plans of health facilities; estimates of future facility needs; and, in a few cases, hospital utilization data. Vital statistics and information used to determine problem areas within a community, such as information on social disorganization, the incidence of various diseases, and housing code enforcement data, are also frequently requested. The urban planning agencies indicate that they turn most often to the local health departments for information.

Requests from health organizations for data are noted by 84 percent of the planning agencies. The greatest number of requests are for population data: projections; census tract data, and socioeconomic data. Of all agencies reporting, 117 state that a health organization requested population data, 33 note requests for housing data, 30 for land-use information, and 21 for development trend information. Less frequently, a planning agency is asked for information on zoning, site locations, transportation, community facilities, or general information on urban renewal.

The survey illustrates that few urban planning agencies possess, or have access to, data on the health system itself. Very few agencies have health statistics available in their own office, such as occupancy rates of short-term hospitals, location of physicians by specialty, indexes of personal health problems, or residential location of hospital patients (see table 6). In many cases, however, the planning agency knows the data has been collected and could obtain it within a few days. About 50 percent of the agencies report that they do not know whether particular statistics on the health care system, including mode of transportation used by different socioeconomic groups to reach major health facilities and annual personal health expenses, have been collected or, if they have, where they are available. This indicates that planning agencies are neither collecting data on the health care system nor are they the repository for such data. At this time, the planning agency cannot act as a "source of data" on the health care system.

Nearly 70 percent of the reporting agencies have received requests from individual medical institutions to provide either information or advice (see table 7 and appendix tables 13, 14, and 15). Often, requests come from established hospitals and other health institutions for information on the sur-

TABLE 6.—*Availability of data on the health care system (summary of responses from the 204 planning agencies)*

Health care data	The information is immediately available in our offices	We know the information has been collected and we could obtain it within a few days	We do not know if the information has been collected
Location of various types of hospital services, e.g., surgery, maternity, etc	41	115	44
Number of short-term hospital beds that meet AHA-AMA standards	29	120	49
Occupancy rates at short-term hospital	23	112	61
Location and number of nursing home beds	32	112	56
Acres of land used by health care facilities	53	65	77
Location of physicians by specialty	9	87	101
Total medical and paramedical employment	9	83	98
Wages and salaries paid to medical and paramedical personnel	1	67	125
Annual personal health expenditures	3	37	152
Indexes of personal health problems in different sections of the community	9	63	121
Annual capital expenditures for health facilities	15	72	105
Residential location of patients using major health facilities	6	38	150
Mode of transportation of different socio-economic groups to health facilities	8	25	162
Incidence of diseases (e.g., TB, VD, etc.) by community subareas	27	99	66

rounding neighborhood in conjunction with their plans to expand on the same site or from new institutions for advice on proposed sites. One agency reports that when the city-county hospital was seeking a new site, it requested advice from the planning agency but then ignored the advice. The agency says it "identified alternative sites and recommended the one [it] thought best, but the hospital board chose a site which the planning agency specifically recommended against." Another planning agency reports that a new health and welfare center has been built on an urban renewal site recommended by the city planning board.

TABLE 7.—*Plan and proposal review*

Plan and proposal review	Number of agencies (n=204)	Percent of total
Individual medical institution asks planning agency for adivce and assistance	140	68.6
Planning agency asks health organization to review its studies	117	57.4
Planning agency asks health organization to review petitions for zoning changes	87	42.6
Health organization asks planning agency to review plans and studies	92	45.0

Nearly 60 percent of the responding agencies report they ask health organizations to review their studies concerning health care facilities and services. Most often, requests are for a review of either the health element of the comprehensive plan or the community renewal program. In a few cases, an urban planning agency has requested a health organization (or an institution) to review renewal plans, especially if these affect the agency or institution. About two of every five responding agencies say that they have asked health organizations to review zoning amendment petitions. In these cases, areawide health facilities planning councils and local health departments are consulted most frequently. In addition, 11 planning agencies refer zoning petitions to the state Hill-Burton agency for review and comments.

Forty-five percent of the responding agencies have been asked to review the studies and reports of health organizations. The majority of these requests come from areawide planning councils, health and welfare councils, and local health departments. Proposed locations for new health facilities and the expansion plans of older facilities are the things most frequently referred to the planning agency.

The most frequent contacts of the urban planning agencies are with three primary health groups: Areawide health facility planning councils because of their concern with facilities and their planning orientation; health and welfare councils because they represent numerous health interest planners; and public health departments because they, like the planning agencies, are public agencies.

The Substantive Work of Urban Planning Agencies

Although most of the agencies responding to the questionnaire have developed a varied set of relationships with the different health organizations, a lesser number have been involved in substantive health planning work. The type of work done by urban planning agencies includes special studies of a health problem, the health segment in the comprehensive plan, a health element in urban renewal plans, and direct participation in federally sponsored health programs.

About one-fifth of the reporting agencies say that they have done special studies devoted primarily to health care services and facilities. The topics of these studies are quite varied, although most deal with facilities and focus on location criteria and site development standards. The subjects under study include such things as location criteria for rest homes, nursing homes, and convalescent hospitals; a model ordinance for hospital parking requirements; medical health center location studies; day-care facilities for children; senior citizen population growth and its impact on geriatric facilities; and zoning and land-use schemes for medical centers. Some of the more important studies prepared by the urban planning agencies are listed in the bibliography.

The 20-percent figure of agencies preparing special studies is somewhat of an overstatement. Some agencies say they have completed a special report on health when actually they have simply included a public hospital or a health center in the capital improvement program, or prepared a small section on health for the comprehensive plan. In addition, some agencies have assisted a health organization with a special study but have not done it themselves. In reality, then, somewhat less than a fifth of the agencies have been primarily responsible for a special study of a local health problem.

Ninety-three agencies, nearly one-half of those agencies which have prepared or are in the process of preparing a general plan, indicate that a section of the plan is (or will be) devoted to health care facilities and/or services (see table 8 and appendix tables 16, 17, and 18). A discussion of public health facilities is included in over 80 percent of the health care sections of the general plans and private health facilities are discussed in over 66 percent of the plans. On the other hand, less than 37 percent discuss public health services, and only 17 percent discuss private health services. The facilities most frequently treated in the general plan are hospitals, both private and city or county, public health care centers or clinics, and community mental health centers. Usually, the plan contains a functional description of these facilities and a map showing their location, as well as locational criteria or site development standards for new facilities.

Sixteen percent of the plans recommend the establishment of an organization to study areawide health needs (see table 8). In many cases such an organization already exists in the area; including a recommendation for its establishment is obviously unnecessary. One agency indicates that although it perceives a "need for a countywide medical facilities planning council and that this was supported by hospital administrators and operators of major nursing homes, the mental health agency, the health department, etc., it was actively opposed by the county chapter of the AMA. * * * Hence, efforts toward [establishing] such an organization have been fruitless."

More than half of the general plan sections are based on the plans or suggestions of one or more of the health organizations existing in the planning agency's jurisdiction, areawide health facility planning councils being consulted most often. It is difficult to know exactly what kind of information was supplied by the health planning organization, or how the information was used, but the fact that more than half of the planning agencies did consult health organizations for help in preparing the health section of their general plan is significant.

TABLE 8.—*Health care services and facilities and the general plan*

Health care and the general plan	Number of agencies[1] (n=93)	Percent of total
Items included in the health section of the plan include description of and/or recommendations for—		
Publicly owned health care facilities	76	81. 7
Privately owned health care facilities	62	66. 7
Public health care services	34	36. 6
Private health care services	16	17. 2
Plan recommends creation of organization to study areawide health needs	15	16. 1
Section in general plan is, or will be, based primarily on plans of one or more of the health organizations[2]	49	52. 7

[1] 93 have a general plan containing a health care section.

[2] Including areawide hospital or health facilities planning council; local health department; health council; health and welfare council; State Hill-Burton agency.

One hundred and five agencies, more than half of the agencies which have prepared a general plan, do not include a section on health care services and facilities. Their reasons are quite varied. A few respondents say that a health section will be included in the next revision of the plan, and a small number of agencies indicate that inclusion of a health chapter was "never even considered." Some agencies just "do not know why"—the staff that prepared the general plan has moved to other jobs. Eleven agencies say that "health care planning was adequately handled by the health organizations." But the largest single group of agencies, 34, report that a section on health was not appropriate for inclusion in the general plan, either because it required too great a level of detail or because the plan emphasized publicly owned facilities and most health facilities are private.

Urban renewal plans, especially the CRP, offer the planning agency an excellent opportunity for substantive work in health care planning. Incidence of personal health problems can be used in establishing priorities for action in renewal areas, and 53 respondents indicate that it was so used. Of the 204 agencies returning questionnaries, 82 (40.2 percent) indicate that their community has prepared (or is preparing) a community renewal program. Among these 82 communities, more than one-third (34.1 percent) indicate the CRP contains recommendations concerning health care services for residents of renewal areas and a little less than one-fourth (23.2 percent) recommend that relocatees receive health care services during or after relocation.

The extent of the planning agency's knowledge of Federal health legislation, the action undertaken in the community with regard to this legislation, and the role played by the planning agency in this regard are all significant in evaluating the agency's overall involvement in health (see table 9 and appendix tables 19 and 20).

TABLE 9.—*The planning agency and Federal health legislation*

Federal health legislation	Number of agencies (n=204)	Percent of total
Planning agencies involved in development of health centers under the neighborhood facilities section of the Housing and Urban Development Act of 1965[1]	64	31. 4
Planning agency involved in efforts to determine impact of Medicare in locality	21	10. 3
Planning agency is familiar with the provisions of the Community Mental Health Centers Act of 1963	48	13. 5

[1] A total of 77 communities of those questioned plan to build such centers

The neighborhood facilities section of the Housing and Urban Development Act of 1965 provides grants for the planning of community health centers. Seventy-seven agencies report that their community is planning such centers. In 64 of these 77 communities, the planning agency has a role in planning the centers. Twenty-five agencies report helping to select sites for the health centers; 13 have helped prepare the application for Federal funds; others have provided either physical or population data on the area surrounding a proposed site; and a few indicate that their primary role to date has been to "recommend that health centers be built."

Title I of Public Law 89–97 (Medicare) went into effect on July 1, 1966. Many observers thought that hospitals would become overcrowded and the demand for nursing homes would be far in excess of supply. About 10 percent of the responding agencies report that they were involved, mostly in a minor way, in efforts to determine the impact of Medicare. One agency reported that—

> * * * at the time Medicare came into being [the] county was in the process of phasing out a TB sanitarium because of declining use. Our agency was assigned to study the possible reuse of this building for welfare office purposes. We did try to determine if Medicare would change the situation so that it would be desirable to consider a medical reuse instead.

Another agency says that it was in the process of establishing "a home health agency for Medicare recipients over 65 years of age"; a third agency reports that it carefully checked reports from various institutions and homes to ascertain "if an emergency would be upon the city in the near future in terms of overload on existing facilities."

In the Community Mental Health Centers Act of 1963, Congress authorized $150 million in Federal aid for the planning and construction of comprehensive mental health centers. Less than one-fourth of the responding agencies are familiar with the provisions of this act. Of those who are directly involved in planning for mental health centers, the majority state that they offer advice on site selection. One agency reports that after the state had selected its city "for the location of the first center, our agency provided data to determine catchment area and assistance in promoting community acceptance of the plan and selecting a site."

Opinions of Planning Agency Involvement

The attitudes and opinions of the responding planning agencies on health care planning are summarized in tables 10 and 11 (see appendix tables 21–24). These tables indicate the reasons planning agencies have not given more attention to health planning up to this time, as well as the extent to which agencies feel they should be involved in health care planning in the future and the nature of this involvement.

For the most part, planning agencies think in terms of "relating to" or "working with" organizations responsible for health care planning. Planners think in terms of giving these organizations "advice and assistance" and of "integrating" health work into the planning agency program.

Almost four-fifths of the responding agencies feel that planning for health care services and facilities has not been covered adequately in their planning program. Yet, there is little consensus on the reason for this. The only reason chosen by more than one-half of the responding agencies is "lack

TABLE 10.—*Reasons why health has not been adequately covered in the planning program*

Opinions on planning agency involvement	Number of agencies (n=204)	Percent of total
Agency feels that planning for health care services has not been adequately covered in their planning program	159	78. 0
Reasons planning agency has not given more attention to health care planning:		
Not enough staff	119	58. 3
Other studies have higher priority	97	47. 5
The health organizations are doing an adequate job	85	41. 7
Lack of technical competence	72	34. 4
Planners do not have a role to play in this field	15	10. 5
Other	28	13. 7

of staff." Other reasons, including "other studies have a higher priority" and "the health organizations are doing an adequate job," are ranked in the same order by all planning agencies regardless of jurisdiction or size of population served (see appendix tables 21 and 22). Only 10 percent of the responding agencies, most of them city agencies, suggest that the reason their agency has not given more attention to health care planning is simply that "planners do not have a role to play." Another reason for not giving more attention to health planning given by a number of agencies is, in effect, "no one has asked us." Answers from two agencies to the question of why they had not given more attention to health planning are particularly revealing:

> The hospitals express a "go it alone" attitude and do not want outside assistance. They appear to be in competition with each other for prestige, staff, capital development, etc.
>
> We had an interest and inclination, but on first attempt HHFA turned us down (and if they disagree, I have the letters to prove it). On second attempt with the local United Community Fund, they first agreed then backed out. Biggest problem is lack of general community interest and drive. Some type of study is now being done on health by the health department, but we do not know the nature of study since we are not invited participants, nor have we been kept informed.

Consensus among the responding agencies on the activities in which planning agencies should be involved is quite high (see table 11). More than 50 percent of the agencies point to five different activities, many agencies indicating more than one. These activities include giving advice to public (85.3 percent) and private (82.3 percent) health planning organizations, reviewing petitions for zoning amendments for health care facilities (83.3 percent), reviewing proposals for new health care facilities (71.6 percent), and preparing a section in the general plan devoted to health care facilities and services (58.3 percent). These activities are indicated by almost the same proportion of agencies regardless of jurisdiction or population served.

TABLE 11.—*Planning agency attitudes concerning planning for health care services and facilities*

Attitudes and opinions	All agencies (n=204)
Activities in which planning agencies should be involved:	
Advising public health agencies	174 (85.3)
Reviewing petitions for zoning amendments for health care facilities	170 (83.3)
Advising private, voluntary organizations	168 (82.3)
Reviewing proposals for new health facilities	146 (71.6)
Preparing a section on health for the general plan	119 (58.3)
Making a comprehensive study of health facilities	74 (36.3)
Preparing site plans for medical centers	51 (25.0)
The attitudes of the agencies concerning their involvement in health care planning during the next few years:	
Our present level of involvement is adequate	30 (14.7)
We would like to play a more active role but will not—	
Because of budgetary limitations	82 (40.2)
Because of lack of encouragement from the planning commission and city officials	31 (15.2)
Because the health organizations will discourage involvement	17 (8.3)
We have plans for expanding our role in this area*	49 (24.0)
No opinion	43 (21.1)

*Examples of means of expansion include: general plan studies, CRP studies, Demonstration Cities grants, zoning ordinance review, and the establishment of closer ties with health planning agencies.

The responding agencies express a wide range of opinions on the future involvement of their own agency in health care planning. A large number feel that they would like to be more involved in the future but probably will not, primarily because of a limited budget. Almost one-quarter of the responding agencies say that they have plans for expanding their activity in this area, either through specific planning agency studies and reports or by establishing closer ties with the health planning organizations. One metropolitan area planning agency reports that discussions have already begun on a comprehensive study to be undertaken by the agency in conjunction with the hospital planning council. Only 15 percent of the responding agencies feel that their present level of involvement is adequate and that they will continue on this level.

Respondents were asked to describe what they consider the ideal way in which planning agencies can contribute to health care planning. The answers are, for the most part, pragmatic. The respondents generally do not want to "take over" health planning, but neither do they want to be left behind. Almost all agencies assume the presence of a health planning organization or organizations and emphasize working with these agencies. A few agencies suggest that they should be the primary planning organization for health services and facilities. The variation in answers reflects, to a considerable extent, the respondents' own philosophy of what urban planning is and what it should do. The fact that there are so many varied responses seem to reflect the unsettled and changing character of urban planning. Some of the more typical responses are as follows:

> If a technically competent health planning staff is not available, a planning agency should, at least, be authorized to act as a review board and/or clearing house regarding all municipal proposals (both public and private) involving health facilities.
>
> By acquiring training health planning personnel.
>
> Provide tabulated data on the various elements of the city that can be used to assist new developments proposed by private enterprise. Advise and assist in site planning for various facilities. Insure compatibility of zoning ordinances with health facilities. Give adequate time, effort, and space to health services in all long range planning and special consideration in the General Plan.

As an advisor on physical planning matters. As a passive participant in health planning. As a sponsor for a comprehensive plan for developing and/or expanding health care facilities and services.

The planning agency can best serve as a communication link, receiving information from many sources and distributing it for most effective utilization. Interagency cooperation is another function most efficiently performed by a planning agency.

Define and analyze our jurisdiction's health problems and existing facilities. Postulate criteria and processes which will produce reasonable solutions to any problems which do/will exist, utilizing all available sources. Establish a specific method and implement it as a cooperative effort of all health agencies active in our planning area.

Firstly, by not trying to do the job for which it probably is not equipped or staffed. Secondly, by cooperating with the official, civic, and [volunteer] (county medical society) groups with a direct, personal, and professional interest in health care planning.

Summary

The agencies surveyed are not active participants in community health planning. Although they have developed a number of "contacts" with various health organizations, the contacts are sporadic and rarely deal with major health policy questions. In most instances, the relationships consist of occasional telephone inquiries, a committee meeting two or three times a year, or an exchange of publications. Rarely is there a sustained and systematic attempt to relate the interests of the urban planning agency with those of one or more health organizations.

In addition, most of the responding agencies have no great ambitions for substantially increasing their participation in health planning matters. Although they are not especially satisfied with their past performances, they also do not envision any major changes in their performance records. They consider health planning a low priority item. They are interested in playing a supporting role, but for many different reasons they do not see themselves as central figures in community health planning.

FIELD STUDIES

In order to give depth and shading to the more general results of the questionnaire survey, urban planners and representatives from a variety of health organizations were interviewed in five different metropolitan areas across the country. More specifically, the interviews were designed to—

(1) identify the kinds of health projects urban planners have been, or are, involved in;

(2) identify the kinds of formal and informal relationships that exist between urban planners and health planners;

(3) identify the problems that inhibit cooperative efforts; and

(4) Identify the mechanisms that have the greatest potential for increasing the kinds and levels of joint participation.

The interviews, conducted at various times during 1967, ranged in length from one-half hour to over 3 hours. The 80 people interviewed represented 36 different public or voluntary agencies and institutions. In most cases, the persons interviewed were members of the professional staffs of the agencies; in a few instances, they were citizen members of policymaking boards or commissions. The types of agencies in which interviews took place are as follows:

Seven city planning agencies.

Five areawide health facility planning councils.

Four metropolitan or regional planning agencies.

Four city and/or county departments of public health.

Four health and welfare councils.

Two county planning agencies.

Two planning divisions of councils of governments.

Two urban renewal agencies.

Two community renewal program agencies.

One each of the following: A community fund organization, a chamber of commerce, a county hospital commission, a health facilities division of a state health department, and an association of public health officers.

Metropolitan Area A

The central city planning department of this large metropolitan area, under pressure for several years to prepare a general plan, published a preliminary document in 1964 setting out broad development policies for the city. This report, which was used as a focal point for citizen discussion and debate, contained no material on health care or health facilities. The city's official general plan, published 2 years later, did contain a health component.

When the preliminary plan was published, the city solicited reaction from citizens, neighborhood groups, and voluntary associations. In response, the health and welfare council raised a number of objections to the report, transmitting their comments to the city planning department. Among other things, the Council noted that no policies whatever were included on the following important subjects: public housing, public safety, housing for the elderly, higher education, the relationship of the city to the metropolitan area, and public health (facilities and services). The city planning department urged the council not to release its comments to the press, but to no avail. Shortly after the council's views were published, the city planning department announced that policies on health, as well as a number of other issues mentioned in the critique, would be included in the final version of the comprehensive plan.

The health and welfare council believes that their critique was a major factor in getting the city to expand the list of issues treated in the plan, particularly the health issue. The city planners acknowledge the influence of the council, but tend to minimize its importance in explaining why they expanded the list. The planning department cites three main reasons for their decision to cover health policies in the plan: First, the Department is now committed to a philosophy of expanding the scope of its activities beyond land use and facilities to include all the activities of government; second, the city's public health department is broadening its concern from preventive medicine to include all aspects of health care; and third, the neighborhood facilities section of the 1965 Housing Act, which includes health care as one of the services to be provided in neighborhood centers, affords a local entree into health problems. The planners suggest that they would have included health in the plan even if the health and welfare council had not issued its statement.

The city planning department assigned a middle level staff man with no knowledge of the health field to prepare the material on health. An early draft outline was sent to the health and welfare council for comments and was reworked after a few joint staff conferences between the two organizations. Some of the health and welfare council's suggestions concerning items to be included in the comprehensive plan were accepted; most were not. Thus, the major role of the health and welfare council was to prod the planning department into thinking about health; they played a lesser role in shaping the content of the final product. The area's health facilities planning council, a strong agency with health planners on its staff, was not asked to participate in preparing the health section of the plan.

Although the planning department clearly took full responsibility for the organization and content of the health section, the planners relied heavily on the city's public health department. This department has a reputation among health personnel outside city government as being largely unconcerned about health planning. Officially, the health department welcomed the planning department's intention to prepare material on health; unofficially, some health personnel felt that the urban planners were getting into an area which was none of their business.

The brief section on health in the general plan specifically focuses on public health facilities and services, and makes a number of general recommendations concerning local health centers, mental health centers, and services for the medically indigent. However, a number of the recommendations do have implications for the private system of health care. The staff of the city planning department comment that they want to "raise issues" rather than "solve problems" at this time. Their justification for concentrating on public health issues has two bases: (1) the health field is unstable at this time, and (2) some private and voluntary health organizations would be touchy about having a city agency intruding into their territory.

There was very little reaction to the health section of the plan once it was published. There was no official response from the health facilities planning council, the health and welfare council, or from any other major public or voluntary health organization. Unofficially, the attitude of health professionals in the area ranged from gratification that the city had at least recognized the health field in a major document like the comprehensive plan to strong criticism about the inadequacies of the treatment of the subject. A few regarded the plan as government infringement on a voluntary field. Most, however, felt the section was far too general to be useful to anyone. The city planning department does not deny the charge that it only touched the surface of the basic health problems within the city, but argues in defense that this is only a first step for a department that has historically had little or nothing to say about the health care system. A more important issue is their subsequent action following this first step; so far the followup, in a substantive sense, has been minimal. However, preparation of the health section has at least served to orient some of the planning department's staff to think about health issues. They are now concerned about the effect of Public Law 89–749, and they are more knowledgeable about the importance of some of the health legislation recently enacted, such as medicare, medicaid, and the OEO community health centers. The planners are beginning to think about the relevance of health facilities and services in the total citywide planning structure.

They recognize, though, that their future progress will be difficult unless they are able to specify exactly the dimension of their role. Here, however, as in the other metropolitan areas, everyone agrees in principle, that the city planning department should be involved in planning for health services and facilities. It seems logical for the department to play some kind of role, but no one is sure what that role should be.

The city planning department sees itself as a coordinator, working in areas where more than one health agency is involved. Their long term goal is to develop good working relationships with all the health organizations, public and private, but at this time they do not want to get deeply involved in any health planning unless it relates directly to the city's public health department. The health department sees the city planning department as a buffer between it and the voluntary or private health interests and as a contact with the outside world. The health department staff believes the planning department's central position within government and its broad perspective could allow it to act as an arbitrator between conflicting public and private or voluntary health organizations. The health and welfare council sees the city planning department as a synthesizing agency, an agency that could provide community sanction for the planning done by other groups.

Most of these views seem to downplay any substantive planning work in favor of a coordinating role. The city planning department will not do health planning; it will arbitrate, coordinate, synthesize, and cooperate, although what it will coordinate or synthesize, or arbitrate is not clear. The planning department, as yet, does not have the expertise that would qualify it to act as a coordinator and, at the moment, it has no intention of further developing its capacity to undertake health planning. Furthermore, it does not really enjoy the respect of the health organizations in the area. Both the health and welfare council and the health facilities council note that a young fellow, inexperienced in health, prepared the health section of the plan. They did not prejudge the quality of the final product but neither were their expectations high. They note the subtleties and complexities of the health system and point out that anyone unfamiliar with the system could easily make gross errors of judgment. Given the level of health expertise of the present city planning department, it is doubtful if either the health facilities planning council or the health and welfare council would view the department as a coordinator or arbitrator.

The fact that the city planning department devoted part of its comprehensive plan to health care is significant; most cities have not done as much. The significance, however, is not that the health section of the plan itself will make much difference, because it probably will not, but that the process of preparing it has, to some extent, broadened the perspective of the planning staff. How this perspective will be utilized remains to be seen.

Metropolitan Area B

In 1965, the central city of this metropolitan area requested that the metropolitan health and welfare council prepare a section of the community renewal program. Because most of the CRP has been prepared by consultants under contract to write sections of the final report, the city has maintained only a small staff within the planning department to supervise the work of the consultants.

The health and welfare council was asked to "* * * describe human conditions in urban renewal areas, assess potential resources available for urban renewal, develop a social resources plan, and propose a method for internal grassroots resident participation in urban renewal planning." While the main focus of the council's effort has been on social planning issues broader than just health, the field study did shed some light on the relationships between two bodies that potentially could meet with each other on health matters in the future. In other words, the contract established a situation in which urban planners and professional health and welfare planners could form opinions about each other and about the strengths and weaknesses of a formal, cooperative planning effort.

The city's view.—The city is pleased with the work of the health and welfare council. The council has been more than willing to cooperate with the city, has kept the city informed as to its progress on the project, and has produced material according to the agreed upon timetable. The director of the CRP thinks that the extensive use of consultants is a good way to undertake such a project. It solves the problem of finding staff for a 2- or 3-year undertaking and, in the case of the health and welfare council, it is an excellent way to integrate an important community organization into the city's program. He also notes that consultants can say things that need to be said—things that could never be said by an official city agency.

Although he has been reasonably satisfied with the use of consultants, if he were to do the project again, the director would make two basic changes, both of which are designed to increase his control over the consultants' work. The council's contract, for example, simply states that the "consultants shall maintain close liaison with planning and other officials of the city." In the contract with the health and welfare council this has been sufficient; it has not worked as well with the other consultants. For each of the subject areas for which consultants are called in, the director would like to have a man on his staff trained in that field. For example, someone trained in social welfare work could work closely with the council. The director is not seeking supervision as much as heightened communication through use of a staff member who could talk the language. He cites three advantages to this approach. First, it would enable the city to keep a closer watch over the consultants' progress. Second, it would provide continuity in the program following the presentation of the consultants' final report; that is, someone on the staff who was knowledgeable about the contents of the report could begin work on implementing the recommendations. Third, it would be a means of providing inservice training for the city's staff. The second change would be to require the consultants to do at least half of their work in the city offices. The director thinks this would give him a better chance to supervise their progress.

Since the contract was signed, the city has begun to use the resources of the council more frequently. The city has, for example, asked the council's director of research to write the social plan section of the model cities application. Individual staff members have developed informal contracts with the council staff and now feel free to call them for advice and information. They feel that if it had not been for this first, *formal* contact, the relationship would not have developed as rapidly or as effectively.

The city planners feel that the health and welfare council is a resource that they can call upon to help them with their social planning. They are not sure how they can best use the council, but the fact that it is there and is willing to help gives them more confidence in tackling projects like the CRP and the model cities program. They are generally content to leave the relationship in its present state. With the exception of the liaison man mentioned above, they are not especially interested in having any social planners or health planners on their staff.

The health and welfare council's view.—The health and welfare council also views the contract as something that benefits both parties. Prior to the signing of the contract, there had been almost no contract between the council and any one of the three major urban planning agencies in the area (a five-county metropolitan planning commission, an urban county planning department, and the planning department of the central city). Now, at least, there is interaction with the city.

The council has two criticisms of urban planners, which are offered as general observations applicable to all urban planners and not as specific criticisms of the city's planners. First, staff members suggest that urban planners simply do not know enough about, or have a great enough appreciation for, the complexities of the social welfare field. Urban planners expect the health and welfare council to provide quick and simple answers to all their questions. The council feels that the planners are too "plan" or "project" oriented and that they fail to understand that planning is a process. Staff members think that urban planners may be interested in getting a social plan section in their report because it is required rather than actually doing any social planning.

The second criticism is that urban planners tends to be like quasiscientists, separate and aloof from whatever it is they are planning. It is felt that this pseudoscientific stance is due in part to the fact that urban planners can make a plan and then carry it out by using the legal and financial powers of the city. This criticism appears to grant considerably more power to urban planners than they in fact possess, but it is a criticism one might expect from a voluntary agency such as the council which has almost no power of its own and which must, therefore, rely on persuasion and suggestions to get anything accomplished. The council thinks that urban planners tend to plan for people more than they plan with people.

The health and welfare council's director of research feels little affinity for physical planners, but notes that the council would like to be heavily involved with those planners who are concerned with the allocation of all the city's resources. He thinks that the projects in which land planners have traditionally been involved are of little importance in solving the health and welfare problems which concern the council. He also points out that as a result of new federal legislation, urban planners are now broadening their scope of interests beyond land and buildings.

He has mixed feelings about the advisability of having the city planning department hire someone with a background similar to his. On one hand, he thinks the city would benefit greatly from such a move since no one on the staff has much knowledge about social welfare planning. On the other hand, he is afraid that if the city did hire someone, the health and welfare council's role would be more limited. The council is developing as a significant influencer of the city's social policies, and the director does not want anything to happen that might jeopardize that relationship. A social planner working for the city could, of course, strengthen the relationship but it could also weaken it if the city decided to do its own social planning. He is not sure, therefore, what he would recommend with regard to the city's hiring a social planner.

Without question, the council thinks that the most important result of its work on the CRP has been that it has given it a chance to influence city policies directly. The council wants very much to continue this relationship and, if possible, to create similar relationships with other governments in the area. It would also like to broaden its contacts with the other two urban planning agencies, but it does not know how to proceed. The council is reasonably certain that such interaction has to begin with a formal agreement to work on specific projects, such as the CRP, since that is the best way for each agency to learn what the other has to offer. Simply agreeing to coordinate is not enough. There has to be some specific project in which each of the organizations has a definite role to play.

In general, the urban planners in this metropolitan area are not involved in the main currents of health and social planning. The health and welfare council is doing a great deal of work within the region and, with the exception of the CRP, it is operating independent of the three major urban planning agencies. The city, in asking the council to work on the CRP, is apparently wisely using an important community resource. Given the tenor of new Federal legislation, it is probable that the city and the council will continue to develop this relationship to their mutual benefit. It is not yet clear, however, whether the city's planners will develop a social planning capability or whether they will continue to do their social planning and health planning by contract," with the health and welfare council.

Metropolitan Area C

The areawide health facilities planning council in metropolitan area C serves about 4 million people in nine counties. It is a federated organization made up of eight separate county hospital planning commissions.* Fifty percent of the board of trustees of the planning council is composed of representatives of the eight local commissions; the other 50 percent is appointed at large. Each of the local hospital planning commissions is responsible for the planning within its own district, with staff assistance supplied by the health facilities planning council.

The planning council is only 3 years old and, with some exceptions, it seems to have won a fair amount of respect and acceptance in this short period. One observer comments that at least the council has managed to get some hospital administrators to speak to each other and to begin to think about the future of their own institutions.

The staff of the health facilities planning council shares the view of many other health planners regarding the desirability of health planning-urban planning cooperation: "That sounds like a good idea. We really ought to be coordinating our programs more since all these planning programs are very much related." As evidence of past interaction, the staff members could relate only a few isolated cases. For example, urban planners in a few areas ask the planning council for help on health facility zoning problems. The health facilities planning council has not, however, given any serious thought to how it and the urban planners can move beyond occasional informal contacts. Although receptive to the idea of more involvement (of some undefined character) with urban planners, the planning council believes that there are other more pressing matters that demand its attention. For the present, it is content to continue with existing informal pattern of interaction.

The council of governments.—The planning division of the region's council of governments has had little previous experience with health planning problems. The staff agrees that it is only dimly aware of the existence and significance of some of the more important health legislation that has been passed during the last few years. Its relationships with the health facilities planning council, the health and welfare council, and public health departments at various levels are reported to be good, although it has had only limited contact with these groups. The health facilities planning council has recently asked the council of governments to cosponsor a seminar on planning for mental health facilities and services for the benefit of health professionals, architects, and urban planners in the area.

The major health concern of the council of governments at present is to develop review procedures for applications regarding federally supported health construction projects under the provisions of title II of the 1966 Demonstration Cities and Metropolitan Development Act. In this connection, they have had one meeting with the planning council but have not yet established any specific review procedures.

The central city and county.—A number of comments by the city-county urban planning department and the county public health department highlight some of the coordination difficulties of the health field itself, illustrating the attitude held by some local public health offices that they are being bypassed by some of the new health legislation which has created new administrative structures rather than relying on existing public health departments. As a result, health departments in many areas have adopted somewhat defensive positions. The following two cases are illustrative.

> (1) The county public health officers complain strenuously about a health center for low-income patients, funded by the Office of Economic Opportunity, only a few blocks from one of their public health centers. They feel it is in competition for the same patients served by their health center. Although representatives from the county public health department are on the policymaking board of the OEO-sponsored center, they feel the OEO center illustrates the lack of coordination between various health programs and services.*
>
> (2) The county's plan for mental health centers, recently released, shows six catchment areas which do not correspond to the five health districts used by the county public health department for the past 5 years. The public health department was not consulted on the problem of establishing the six mental health service districts, nor was the city-county planning department. The planning department was asked to comment on the six-district mental health plan after the plan had been completed and essentially approved. The

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*In one case, two counties have formed a single planning commission.

*One health expert at a nearby university later indicated that the county public health center had never made an honest effort to serve the health needs of the poor. He sees the OEO center as a possible means of remedying this deficiency.

> county public health department thinks the six-district plan should be opposed, and cites this as another failure of coordination.

The city-county planning department has been involved in health matters in three primary ways: Through the capital improvements program, through the zoning ordinance, and through a special study of the location of public health centers.

The director of the capital improvements program for the city recently assigned one of his staff to investigate all Federal and State health legislation in order to categorize the types of facilities for which some form of financing is available. Theoretically, this was to enable the director to chart the number and type of health facilities the city could afford to build over the next few years. Unfortunately, the project is about to end in failure since the person assigned this responsibility found that it is almost impossible to obtain complete and up-to-date information in the health field. He claims that health legislation and amendmends to previous legislation are emerging so rapidly that it is impossible for him to determine accurately how much money is available and for what purposes.

The capital improvements section of the planning department does work closely with the public health department, just as it works with all of the other city's operating departments. There is no evidence, however, that the capital improvements division has any particular expertise in health matters. A request for a new health facility is not any different than a request for a new police station—they are both large and municipal expenditures that must be weighed in the priority schedule of improvements. The method of establishing priorties for health facilities is no more clear than it is of establishing priorities for any other category of facilities.

In 1960, the public health department asked the planning department to prepare a report on the location of public health centers. The purpose of the report was to "present for public consideration and approval or modification a plan for the location of district health centers * * * which can be included in the master plan for the city and county to serve as a guide in the future physical development of the health center system."

The author of the report stresses the importance of close and continued contact with the public health department in preparing a study of this kind, and reports that several weeks were initially spent in the health department just meeting people and learning the language. The report divided the city into 10 districts and within each district located a possible site for a health center. Following a review by the public health department and a public hearing, the report was adopted by the city-county planning commission as part of its master plan.

In 1962, the public health department reorganized its program, in the process discarding the recommended 10 health-center districts in favor of five larger ones. Administrative considerations dictated the modification. The planning department was apprised of this change, and the district alterations were reflected in the 1962 capital improvements program and those subsequent. It was not, however, until 4 years later, in 1966, that the planning department revised its official health center location plan in order to "reflect more accurately the [1962] reorganization and decentralization of the district health services offered by the public health department." Although personnel from the department claim that the city-county planning department was helpful on the district health centers, it is difficult, from this perspective, to appreciate this. It looks more like the planning department prepared a report that became outdated in less than 2 years, and then 4 years after ratified the revised version of the plan that was prepared by the public health department. The planning department was helpful in identifying possible specific sites for centers, but beyond that, their contribution to the area's health center plan was limited.

Another city.—The city planning department of a second large city (378,000 population) in the region has produced three special reports on health-related matters. One of the reports is a district plan that has been adopted by the city council as an amplification and elaboration of the general plan. A plan for the growth and development of an area of the city with three hospitals and many other health or health-related facilities, the report was done by the planning staff with assistance from a committee of health professionals from the area.

The report sets forth four general goals and lists a number of suggestions for achieving these goals, most of which deal with the physical development of the area (streets, parking, etc.). However, the report also includes a number of recommendations suggested by advisory committee members concerning patient referrals systems, intern programs, sharing of facilities, and many other items that are of direct interest to doctors and hospital administrators.

The report is now 8 years old and the follow-up is described as slow and disappointing. The report did result in a major amendment to the zoning ordinance, leading to the creation of a medical center district. Perhaps most important, the people in the area are pleased that the city exhibited so much concern and interest in the future of the area. This is cited as a psychological benefit of the report that has resulted in a greater degree of cohesiveness and cooperation between the many different health-related institutions in the district. Many of the proposals have not been carried out, but more people are now beginning to think of the area as a unified medical district, to some extent as a result of the publication of the report.

A report on children's day-care facilities was designed to determine the attitudes of the people living near existing facilities. The request for conditional-use permits for day-care facilities in residential areas always seemd to elicit strong negative responses from neighboring property owners. It was felt that the fear and apprehension of the objectors was out of proportion to the actual impact of these uses. The study was designed to see what, in fact, was objectionable to the neighbors of existing facilities, and to see what conditions might be attached to a conditional-use permit which would control some of the more objectionable characteristics of these uses. The report, prepared by the planning staff, with advice and assistance from the health and welfare council, the public school system, and the State Department of social welfare, was transmitted to the planning commission and has proved useful to them in evaluating applications for use permits, although it has not resulted in a specific amendment to the zoning ordinance.

The third report, on nursing homes and homes for the aged, was initiated following a large number of zoning cases dealing with these facilities. It was, again, done by the planning staff with assistance from the health and welfare council and the health facilities planning council. The report has been useful in administering the zoning ordinance and has led to some text amendments. It, like the others, was prepared to assure that the zoning ordinance would not handicap the development of needed health service facilities.

In general, the interraction between health planners and urban planners in this region is problem-responsive. The contacts are made at the staff level and are usually not sustained past the staff at which particular problems are solved. Several of the urban planning agencies seem to make effective use of the resources of the health institutions. As one of the urban planners puts it: "We're glad that they [Health and Welfare Council, Health Facilities Planning Council, etc.] are over there, it's good to know someone knows something about this." There is, however, no continuing effort to coordinate programs and plans. This is not surprising. Both the urban planners and the health planners are very much involved in their own activities, most of which have little to do with each other. To both groups, the time and expense of an ongoing exchange of information or permanent organizational linkage simply is not worth the limited results.

Metropolitan Area D

The health facilities planning council in metropolitan area D is one of the oldest in the country. Numerous ideas and practices pioneered by the council are now being used by many of the 70 or so councils currently operating throughout the nation. During its more than 20-year history, the council has had many opportunities to work formally and informally with the city and regional planners of the area.

Like many other councils, the initial source of support came from local businessmen and philanthropists who were being asked for more and more donations to support hospital construction projects, and who had no way of judging the legitimacy of the requests for their funds. The council was established to balance the competing demands against the available resources. Although its major interest has been and still is the hospital system, it is branching out into other areas of interest, and there is a good possibility it will become a comprehensive health planning agency under Public Law 89–749.

In addition to being one of the oldest planning bodies, it is also one of the strongest. It is difficult to imagine any major change taking place in the local health facilities system without the council, clearly the strongest health planning body in the metropolitan area, playing a major and determining role. Since its beginning in 1945, much of the council's strength can be attributed to its successful attraction of top community leaders to its board of directors and to its many committees. The result of this longstanding policy is that today it enjoys the active support of the most influential citizens of the area. As one observer put it, "the council's annual dinner is one of the more important social events of the season, complete with cadillacs and mink coats." With this kind of backing, doors open more quickly and money flows with ease. The council does not compete with powerful community interests; it works with them.

Its strength does not, of course, depend solely upon a big-name governing body. It is strong because, in one way or another, it controls the money that health institutions need to expand or rehabilitate their facilities. First, all applications for Hill-Burton grants are submitted to it for informal review and comments. Although its recommendations are not binding upon the State director of health, who has the legal authority to grant or deny requests, it is probable that a "no" vote from the council would effectively kill a project. Second, the council is unique among health planning bodies in that it conducts periodic, consolidated fund drives for its member hospitals. It is, therefore, in a position to influence the way in which these funds are distributed to individual hospitals. Third, the State has enabling legislation that permits counties to pass bond issues, the proceeds of which are used to finance capital improvements for nonprofit hospitals. Although the council has no authority under the legislation, it does sponsor bond issues, influencing the allocation of moneys obtained from them. Finally, before issuing a loan, mortgage lending institutions regularly ask the council for an informal approval of a proposed project. Thus, the council, by virtue of its past record and the respect it enjoys in the community, influences the financing of hospital construction. These various financial levers, plus the representation of top community leaders on the council's board, place it in a unique and powerful position between individual health institutions and the communty.

Various persons in the field of health planning have criticized the council for its policy of having hospital administrators, hospital trustees, and medical professionals constitute a majority of its governing body. Critics claim that this biases the organization in favor of the medical-hospital establishment, resulting in an absence of fair representation for public consumers of health services. Many health facility planning councils in the country do deny representation to hospitals and doctors. They argue that this is the only way to represent the public effectively. The staff of this council argues, in turn, that they are unbiased, that they are free to oppose their member hospitals if necessary, and that it is foolish to plan for hospitals without the cooperation of the hospitals and the medical profession.

Regardless of the arguments and counterarguments, it is widely accepted that the council is not a tool of the hospitals and that it is a community-minded organization. Even its severest critic admits that the council is honest, that it has a technically capable staff, and that it has saved the city considerable money by cutting down on the duplication of expensive facilities and by proceeding with hospital development according to a well-defined plan. This is a record few cities can duplicate. However, in light of the requirement in Public Law 89–749 that a majority of the members of the policymaking board of a comprehensive health planning organization be health consumers rather than health providers, the council's board composition is certainly open to question and indeed revision, if it is designated the planning body for the area.

The most serious criticism one can make of the council is that there is no check on its activities; within certain broad limits it is answerable only to itself. There is no organization, public or private, with the experience, knowledge, or power to effectively evaluate or challenge the council's decisions. The only real checks are internal. By appointing many people with varying community interests and points of view to its numerous committees (long-term care, planning, financing, personnel, etc.), the council attempts to ensure that its decisions reflect the best interests of the general public.

Based upon a brief examination, the council appears to be a well-staffed, honest, and effective organization. This feeling is, in part, the result of the staff's confidence—or over confidence. They are certain they are doing a good job, and have little concern regarding any opposition. "If we run into trouble, we can always go to X who is a board member and a close friend of Y who will take care of the matter." The council has reason to be confident, of course, since it has a history of many substantial successes. However, it does appear that there would be little recourse for anyone who did not meet the approval of the council.

The strength of the council and the respect it enjoys are stressed here for two reasons. First, the apparent confidence and efficiency with which it carries out its assigned tasks stands in contrast to the more faltering work of the central city and regional (a single county SMSA) planning agencies. This fact seems apparent to the urban planners, one of whom says "the most important thing I've learned from working with the council is how a good planning group is organized and run." The comparison is, of course, unfair since the urban planners have fewer resources, are buffeted by a variety of political pressures, feel a greater need to accommodate a greater range of views in their programs, and have a far more complex assignment than the council.

Second, in all matters related to health, the urban planners must defer to the judgment of the council. The urban planners in this metropolitan area claim no great knowledge about the problems of health planning and, further, they do not care to know much more than they know now. They argue that "as long as the council is here, we don't need to know much about health planning." They believe the council is doing a good job and, even if they did have doubts, they realize that the council, because of its strength, cannot be easily opposed.

The thrust of health planning in the area is controlled by the Council. The role of the urban planners is largely indirect, and consists primarily of two things: (1) the urban planners recognize the council, they seek the advice of the council, and they try to use its resources to solve their own health-related problems; and (2) in an unstructured way, the urban planners keep the health planners informed as to community trends—future highway plans, renewal plans near health institutions, general population trends, etc. The council does not use urban planning agency data, preferring to collect its own or to use census data or data collected by the state. When queried, the staff could not think of any data they would ever need that would or could be collected by the urban planners.

In general, the working relationships between the urban planners and the council appear to be good. These relationships can be illustrated best by reference to three instances where interaction was necessary. The council's planning committee, the health facilities section in the regional plan, and zoning for health facilities.

The planning committee.—The planning committee of the health facilities planning council is, in effect, a reviewing body for all proposals concerning the construction or rehabilitation of health care facilities. Any organization interested in developing health care facilities must make a detailed presentation before the committee, including a site plan, a description of the type of facility, a list of the sponsors, a description of how the construction will be financed, and a variety of other facts pertinent to the proposal. The committee has no legal authority to require such a presentation but, since it would be close to impossible to get a bank loan, Hill-Burton money, or a zoning change without committee approval, the presentation becomes a necessity.

The committee consists of about 15 community leaders, including the directors of the city planning department and the regional planning agency. This is the most permanent and probably the most effective relationship between the council and the urban planners. Both planning directors are highly satisfied with the arrangement and both feel they have learned a lot about health planning as a result of their participation. They usually learn about a new health facility proposal through the committee, for this is where a developer makes his first contact with the community. For the most part, their comments relate to the proposed facility's position relative to existing or planned uses, and its impact on the transportation system. Both directors consider their contributions to committee deliberations small, but significant.

The practice of having urban planners sit on this kind of committee appears advantageous to all concerned and one that could be used succesfully in almost any community. Although one former member of the committee notes that the committee simply rubberstamps the council staff's recommendations, the urban planning directors and the council argue that even if this is the case, the committee is still a useful and important means of keeping each aware of what is happening within the community.

The regional plan.—The regional planning agency is in the process of preparing a regional land-use and transportation plan. It is a major 3- or 4-year effort, financed in part by the Bureau of Public Roads and HUD. One element of the plan is an inventory and projection of space needs for hospitals and other health facilities, which has been completed by the health facilities planning council. The outline for the study was prepared by a junior staff member, an associate planner, of the regional planning agency. Although the outline does request information on services and facilities, the major emphasis is on determining space needs and probable locations of facilities in 1985.

The health planner on the health facilities planning council's staff who worked on the project thinks the outline is somewhat confusing and in some instances unrealistic. The thought of making projections to 1985, in view of the many significant changes now taking place in the health field, is particularly distrubing. He points out that the vast number of unknowns make it difficult for the council to think in terms of what will be happening in 1985. The staffs of both organizations think that a basic communication problem exists between them. The council staff cannot understand what the urban planners require, and the urban planners cannot understand why the council thinks the assignment is so difficult. The first draft of the report prepared by the council was not accepted by the urban planners because it did not give detailed acreage figures for 1985. The revised draft has been accepted, but the council thinks the revision is of questionable value and does not understand how the material is going to be of use. The attitude of the council seems to be: "We will do it, but we don't see what good it is and we doubt if it will be of any use in establishing a community health facilities system."

The urban planner working on this project, who devoted approximately 3 weeks to the project, met with the staff of the council six or seven times during the 7 or 8 months it took to write the section. He says he learned a little about health planning. He and the director feel it is unnecessary to learn any more because they are land planners and they can always call upon the council if they need site or location standards. When asked what they would have done if there were no group capable of doing the work of the council, they answer that they would have attempted the section, but that the result would probably not be as good as what the council has done.

Zoning.—The council plays an informal but important role in zoning for health facilities. It is routinely consulted on zoning changes and special use permit applications relating to health facilities, both in the central city and the suburbs, and on the wording of certain provisions in the city's zoning ordinance.

A few years ago, the council prepared a short report on parking standards for health facilities. When the city began a revision of their offstreet parking standards, they used the figures in the council's report. The council, somewhat embarrassed, appeared at the public hearing and argued against its own standards, pointing out that they were intended for new facilities, not for older ones in the central city where the cost of land would make it prohibitively expensive to meet such standards. The council's view prevailed and standards were revised downward.

The health facilities planning council was instrumental in getting the city to include residential uses in a medical center district. It argued that housing for hospital employees, particularly nurses, should be considered an essential part of any such district. The council also reports that it receives many informal inquiries concerning the need for particular health facilities from the members of the board of appeals and from the city director of zoning. It is difficult to know how much weight is placed on the information received, but is it significant that the council is consulted.

In this metropolitan area, there is indeed a set of loosely defined relationships between urban planners and at least one particular group of health planners which is undoubtedly beneficial for the region. There is an accepted line which roughly demarcates areas of responsibility and interest. The urban planners are pleased to have the council's assistance and the council seems willing to give it. As long as there is no conflict, their respective positions and their relationships will remain secure and intact.

One wonders what would happen if a conflict issue did arise. Presently, many voluntary hospitals throughout the Nation are anxious to move from the decaying neighborhoods of central cities to the suburbs where the "better," wealthier clients live. This is a matter of no small concern to central city mayors who face the prospect of having an increasingly dependent, low-income population and a corresponding loss in health facilities to care for them. This is not necessarily what is happening in metropolitan area D, but what if it were? It is doubtful that the city planning department could supply the mayor and the city council with good technical arguments as to why a particular hospital should remain in the central city rather than move to the suburbs. More than likely, the issue would be resolved by the health facilities planning council's governing board, the ultimate resolution depending upon how much influence the central city has on the board.

In short, the urban planners in this area make marginal contributions to the development of the community health system. They do not influence policymaking, they do not supply data to the health planners, and they do not act as coordinators. With regard to health problems, the urban planners operate very much within the shadow of the council.

CONCLUSIONS

What is the present role of the urban planning agency with respect to planning for health services and facilities? What are the prospects for the future? Although the questionnaire survey and the field interviews provide mixed answers, answers that vary with time, place, and circumstance, they also bring to light a sufficient number of patterns or themes to permit the following general observations:

> Urban planners are unqestionably more aware of, and more sensitive to, what is happening in the health field than they were 5 years ago or even a year ago. Although their knowledge of the health system and the importance of health in the total community is still quite limited, it is growing.
>
> Although urban planners are aware of some of the trends in the health field, they give little thought to how these trends affect their work or to what role they should be playing with regard to community health problems. They are generally aware of the significance of medicare, the importance of Public Law 89–749, the "crisis in health," and so on, but are unable to place this information into a meaningful frame of reference.
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> Urban planning agencies are participants in various health planning projects, but their participation is segmental and sporadic. The various examples of cooperative efforts between urban planners and various health organizations are isolated attempts to meet immediate problems, not permanent features of a larger urban planning-health planning structure.
>
> Most of the contacts between urban planning agencies and health planning organizations are informal, a phone call or an occasional meeting. Almost all the interaction takes place at the staff level. The tendency is to let professional staffs work together as needed, rather than make commitments at the policymaking level of the planning commission or the health organization board.
>
> It is not apparent (to the health planner) that urban planners can bring any special knowledge or skill to the health planning process. There is no evidence that urban planners are either advancing or retarding the attainment of objectives held by health planners.
>
> Health planners turn most frequently to urban planners for information about the future development of the community: Expressway locations, land availability, and so on. Urban planners, however, are not regarded by health planners as a primary source of data.
>
> Urban planning agencies commit a negligible amount of their time, manpower, and financial resources to community health planning.
>
> The most productive relationships between urban planning agencies and health planning organizations occur in those infrequent instances where there is a formal, joint project in which each party has an assigned responsibility.
>
> Although urban planners possess a great deal more knowledge about planning techniques than do the health planners, this information is not shared with health planners.
>
> There is widespread—but not universal—agreement among both urban planners and health planners that more could, and should, be done. These practitioners are not satisfied with their own past records of cooperation, and are generally receptive to the idea of improving their own performances. They recognize that they have only begun to explore the possibilities of working together or using each other's resources.

Finally, it must be noted that although

there is a general interest in exploring further opportunities for improving working relationships with each other, this is not considered a high priority item. Both the urban planners and the health planners see far too many other problems that require their immediate attention; because of this strain on their resources, they have a willingness to improve their relationships but not the capacity to do so.

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Chapter IV

URBAN PLANNING AND HEALTH PLANNING: BARRIERS TO IMPROVED RELATIONSHIPS

If substantial progress is to be made toward creating permanent and effective cooperative efforts in the future, there must be a clearer understanding of the barriers that have kept urban planning and health planning as largely separate community activities. Unless appropriate action is taken, the barriers that have retarded progress toward more integrated planning in the past will continue to do so in the future.

Listed below are a series of explanations as to why urban planning agencies have not been playing a greater role in health planning. Each of the explanations is both a look back and a look ahead: A backward look to determine why there has been relatively little progress to date, and a look ahead to determine what must be done to assure a more successful future.

THE ABSENCE OF A STRONG HEALTH PLANNING MOVEMENT

An obvious, yet important explanation of why urban planning agencies have not been playing a larger role in health planning is that comprehensive community health planning is relatively new. In most communities, there has been little focused or sustained interest in health planning. Only in the last decade has the idea of health planning gained much acceptance, and only recently has substantial progress in terms of legislation and the creation of health planning structures been evident. In many communities, there is still not activity that could reasonably be described as health planning. *Until the health industry fully accepts the idea of comprehensive community health planning, and creates identifiable, effective health planning structures, it is unlikely that urban planners will be effective contributors to (or initiators of) a community health planning process.*

This problem has been evident throughout the study. Many urban planners fail to identify local health planning activities, not because they are unobservant, but because there is very little to identify. The following two responses to the question, "why has your agency not given more attention to planning for health services and facilities," typify the problem.

> This [health planning] has not been a problem of great concern in this community.
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>
> At present there are 2 major hosiptals—one osteopathic and one for M.D.'s. Neither is presently concerned about duplication of facilities whatsoever. The problem is undoubtedly a professional one, and the community must pay the price for their lack of concern.

The respondents are, in effect saying that they can see no reason for getting involved in health planning as long as the health professionals fail to recognize the existence of community health problems and the need for planning.

The initiative at this point clearly lies with the health industry to establish a structure that encourages, or at least permits, participation by urban planners. Health planners must know where they are going before urban planners can be integrated into the process. The evidence available suggests that this is one barrier that will probably be overcome with the passage of time. Health planners are accelerating their efforts to define who they are and where they are going. Hopefully, the organizations created through Public Law 89–749 will provide the necessary framework for encouraging participation by urban planning agencies.

FRAGMENTATION OF HEALTH PLANNING

Even in those areas that can boast significant planning activities, fragmentation of the health system tends to restrict the urban planning agency's capacity to make contributions. Planning agencies can, and do, assist individual health organizations, but their segmental participation does not move the community any closer to comprehensive health planning.

Typically, urban planning agencies face the problem of locating the center, or locus of decisionmaking in the health field. They are confronted with a shifting cluster of health organizations, including health and welfare councils, areawide health facility planning agencies, mental health planning councils, public health departments, and many others. Each one is interested in a part of the total problem but together they are unable or unwilling to attack the problem as a whole. The urban planner finds it frustrating and time consuming trying to cope with this diversity of opinion and authority. Often, the planner has taken the path of least resistance, ignoring the problem rather than getting involved in disputes among health organizations.

Again, comprehensive health planning legislation as embodied in Public Law 89–749 should help to break down this particular barrier. If the law can successfully mobilize interest and support from all the diverse health organizations in the community, then the planner will find it much simpler to be a contributor to the process.

It will, however, be some time before the benefits of the legislation are known; even then the urban planner cannot expect to see complete unanimity of opinion among health professionals. The issues are too complex and the vested interests too strong to expect complete agreement on what the problems are and how to solve them. Furthermore, the intent of Public Law 89–749 is not to establish a single voice for community health service systems, but to establish a format for discussing and researching problems of mutual importance and a mechanism for arbitrating conflicts of interest.

The urban planner, therefore, must not use the fragmentation of the health field as an excuse for inaction. Although there is no single organization in health that is analogous to, for instance, a school board in education field, this in no way frees the planner from whatever responsibilities he may have in the health planning process. There can be no doubt that the fragmentation complicates a planning agency's efforts to make a contribution; it does not, however, excuse it from trying.

HEALTH PLANNING OPPOSITION TO URBAN PLANNING PARTICIPATION

A much more serious barrier exists when health planning organizations resist or refuse assistance from urban planning agencies. In some communities, serious antagonisms have already developed which will impair any possible future relationship between urban planners and health planners.

Thirty-eight of the 204 agencies that returned questionnaires indicate that they think there are health organizations in their areas that would resist or resent their getting involved in planning for health services and facilities. Slightly less than 20 percent of the agencies have either experienced some resistance or else have received indications that their participation would not be welcome. The following comment from one of the respondents appears to illustrate the kind of problem faced by at least some urban planning agencies:

> The general attitude on the part of the potential consumers of our health planning activities, i.e., hospital boards, etc., is that we should not play a role in health planning. We are willing, but our advice is considered an intrusion in the sphere of hospital administrators.

This comment appears to be true in far too many communities. When the hospitals themselves (as well as other health institutions) are more interested in competition than cooperation, it is not surprising that they resist the intrusion of a planning agency. Institutions that will not work with each other are not likely to want an outside party looking into their affairs. They have too much at stake in maintaining the status quo to allow an urban planning agency to plan for them or with them.

From the urban planner's standpoint, there is a fine line between making a contribution and pushing into areas where he is not welcome. Often it is difficult to tell when the line has been crossed. A number of health planners interviewed during the field studies are deeply concerned about this problem. In one community in particular, they are worried that the urban planners, who have recently undertaken a small health planning project, have become too aggressive. They claim the urban planners are moving into an area in which they have no experience, and therefore have no sensitivity to the subleties and the political realities of the health field. They think the urban planners may alienate many interest groups by their "bull in a china shop" approach, thus endangering their capacity to make any future contributions.

If the position is taken that community health is a public problem, there is no reason why the urban planner, or anyone else for that matter, cannot speak out on local health issues. Since some in the health field see health problems as essentially internal ones to be solved by health experts, they contend that because the urban planner is obviously not a health expert he should keep quiet. Unquestionably, the problems must ultimately be resolved by health experts, but this does not mean that outside ideas and assistance should be refused.

The response of the urban planning agency to possible resistance from health organizations should be to recognize the immensely complex character of the local health service industry, and to appreciate the fact that an overly aggressive and simplistic approach to health problems may tend to alienate important segments of the industry rather than lead to any real progress. However, the agency should not adopt a wait-and-see attitude or be led to think that it has no role whatsoever to play. If, for example, the agency has an opinion as to the proper location of a new medical center it should make this opinion known. Indeed, it should argue its case to the limits of acceptability, for the urban planner is a public spokesman and as such is derelict in his duty if he does not press for a decision he thinks to be in the public interest. He does not have the health expertise of the health planner, but he does have a different kind of expertise that is no less important.

REJECTION OF HEALTH PLANNING BY URBAN PLANNERS

Some urban planning agencies have, for one reason or another, already removed themselves as potential contributors to health planning. Their attitude may result from vague philosophical objections (it is not proper for urban planning agencies to do this kind of work) or from the feeling that health planning is being adequately handled by existing health organizations.

Often an urban planning agency's conception of its role, because it is narrowly defined, does not allow it to participate in health planning activities. For example:

> From a planning standpoint, we prefer to evaluate land use rather than become involved in community-wide programs which may go beyond our comprehension.
>
> [We] feel we can furnish much basic data to others to enable them, as specialists, to put a package together.
>
> We feel our responsibilities for general planning at the regional/metropolitan scale have not yet been fully discharged. Planning for health care facilities would introduce a level of detail inconsistent with other plan elements. Physical means are given greater priority. This agency is not set up to do social planning.

The arguments that an urban planning agency's role extends only to land use problems explains in part why urban planning agencies have not in the past been major contributors to health planning. With the exception of large health facilities, health activities are usually not tied to special purpose buildings nor do they require large amounts of land. Many health services can be easily moved and many health services agencies require nothing more than office space. Health programs can be, and often are, planned without reference to physical planning.

The Community Mental Health Centers Act (Public Law 88–164) provides a good example of this problem. The legislation provides financing for a cluster of mental health services, which may or may not be housed in a single mental health center. The primary intent is to provide and organize services, and secondarily to provide funds to house services which are not yet adequately housed. It is, therefore, possible for a community to take advantage of the Community Mental Health Centers Act without even building a mental health center and getting involved in land use problems. The urban planning agency that limits itself to land use problems would have absolutely no role to play, yet there are a great many possible contributions it could make if it would expand its definition of responsibility.

On the other hand, even the urban planner who considers himself only a land planner has a clear and important role to play in health planning. A new hospital, for example, is a highly specialized building: It cannot be easily relocated, it uses large amounts of land, and is a major traffic generator. Health institutions have been negligent in that they have failed to give more thought to land use and transportation problems. For example, only in the last few years had there been wide recognition that some population groups, particularly the poor, have not been receiving adequate care because of the inaccessibility of services. After the riot in the Watts section of Los Angeles, for example, it was found that the standard reply to a resident who said he was sick was: "Yes, but are you $10 sick?" The $10 was in reference to the cost of a taxi ride to the nearest hospital, the alternative being an exceptionally time-consuming and inconvient trip by public transportation.

Increasingly, health services are being thought of in terms of their accessibility. Some hospitals are experimenting with the idea of running special buses to the more remote neighborhoods they serve, as they begin to perceive that transportation is one important element of a total health care package. It appears that the urban planner would do well to encourage this kind of thinking and to assist in making services as accessible and convenient as possible.

In addition to those urban planning agencies that in effect define themselves out of health planning, there are a substantial number who, though willing to participate, feel it is unnecessary to do so because existing health organizations are already doing an adequate job. These agencies sidestep the issue, claiming that they have no role as long as others are doing the job. For example:

> Health care studies have been undertaken by other local agencies. Quality of work done has been good. The need for immediate involvement by our agency is not as important as in other areas.
>
> The health agencies appear to be doing a good job. For us to do it would involve a wasteful effort under present circumstances.

These agencies are, in effect, leaving health planning to the health organizations, yet they are ignoring the question of how they might contribute to improving local health planning efforts. Furthermore, few urban planning agencies are competent to judge whether or not the health organizations are doing a good job.

LIMITED RESOURCES

In many instances, an urban planning agency would like to increase its participation in health planning but chooses not to because it lacks the necessary financial or manpower resources.

Forty percent of the agencies surveyed, for example, say that budget limitations will keep them from playing a more active role in the future. Lack of funds is, of course, another way of saying that other things the agency is now doing have a higher priority than health planning. If the planning commission or city officials want an urban planning agency to become involved in health planning, they can make additional funds available or else alter the order of priorities. It is apparent that most do not yet believe that health planning is an important enough activity to require the allocation of more resources.

Those who want to see urban planning agencies involved in health planning must be prepared to pay the cost. Evidently, the Federal, State, and local governments are unprepared to do this and, until they are, participation is likely to remain marginal. One possibility that requires further exploration is for those health organizations having planning money available to contract part of their work out to urban planning agencies.

The lack of specially qualified manpower resources is an additional barrier to urban planning agency participation. Simply having enough money is no guarantee that an agency can solve its manpower problems. Many urban planning agencies have unfilled staff positions that they carry year after year. Finding urban planners to fill thesce vacancies is difficult; finding people qualified to work in health would be even more difficult. With the very rapid rise in health planning programs of all kinds, staffing problems for the health organizations, let alone the urban planning agencies, will be critical. Graduate degree programs in health planning will help fill the gap, but they will obviously not be able to fill total needs during the next few years.

The fact that urban planning agencies do not have staff familiar with the health service system was commented upon frequently during the field study interviews. Generally, health planners view the urban planners they come in contact with as, nice guys with little understanding of health. How much the urban planner should know depends, of course, on what he is attempting to do, but it is evident he must be aware of certain basic health issues if he is to earn much respect from health planners.

In one of the cities visited, the staff problem seems particularly acute. The urban planners, undertaking a major health service study, assigned a middle level staff person as director. The executive director of the areawide health facilities planning council reports that if the urban planning project is in any way contrary to the reports of his council (a distinct possibility in this case), he will not hesitate to object publicly, if necessary pointing out that the work was done by someone with no competence in health. He will attack the qualifications of the author as well as the report itself. In this instance, the urban planning agency is at a distinct disadvantage because it does not have someone on its staff with recognized health planning capabilities. This is an extreme case certainly, but it does illuminate one more of the possible barriers to effective cooperative planning.

In the final analysis, of course, it must be recognized by both urban planners and health planners that each has a distinctive contribution to make and that neither is in direct competition with the other. They both must recognize that there is a minimal level of understanding and appreciation that must be reached before any real progress can be made in intergrating their programs.

LACK OF KNOWLEDGE

One of the most serious barriers to closing the gap between urban planners and health planners is the lack of an adequate understanding of the relationship among the physical, economic, educational, welfare, and health aspects of urban life. There is, in other words, a knowledge barrier to integrated health and urban planning.

This problem receives far too little recognition. There is a tendency to overlook the limits of our understanding and assume that because integrated planning is desirable, it is possible. There is, of course, a growing recognition that social problems cannot be solved by breaking them down into neat and orderly categories of health, economics, recreation, and so on. The city is, to use the current vocabulary, a system, all parts of which must be related to each other. Obviously, the confining walls of specialized disciplines must eventually be broken, but so far the contributions of the systems analysts are primarily conjectural or hortatory. Their work is of little practical value to a working health planner or urban planner facing real problems and the need to provide immediate answers.

The health system itself is only dimly understood. Health planners have difficulty relating, both in a conceptual sense and in an operational sense, the work of a hospital with that of an extended care institution, or mental health clinic, or community health education program. Although urban planners have made impressive gains in understanding the dynamics of land use and transportation systems in metropolitan areas, they too have much work to do before their systems research becomes operational enough to effectively influence public decisionmaking. Each group is still seeking to understand the respective system in which it operates. Given this absence of adequate conceptual understanding of the relationships within community subsystems, it is extremely difficult to document relationships between subsystems. Urban planners and health planners have a great deal of work to do in understanding their own arenas of interest before they can work together on any basis other than intuition and common sense. This knowledge barrier to integrated planning is much higher than most people want to admit.

THE REGION v. THE CITY

Another problem is that health planning is usually organized on a regional basis, thus, the urban planner's capacity for engaging in health planning is limited. Most health planning work is done at a metropolitan scale. Most voluntary agencies and organizations established through Federal legislation cover entire metropolitan areas, and even public health is often a county function rather than a responsibility of individual municipalities. From the point of view of some city planning agencies, this shifts health planning responsibilities from them to a county or regional planning office. For example:

> Planning and operation of health care facilities must be done on a metropolitan basis in an area such as this with 31 incorporated cities. This is properly a function of the county planning board with which the city is cooperating.

The last part of the above comment ("with which we are cooperating") is significant, for although health planning should be done on a regional basis this does not mean that there is no role for a city planning department. Obviously, a city agency can be involved in locating health facilities within its own jurisdiction, and perhaps in supplying basic socio-economic data to regional health planners.

The jurisdictional problem is also of concern to health planning organizations. In this case, it is a problem of coping with the fragmentation within urban planning. If, for example, an areawide health facility planning council wants to obtain information on zoning from urban planners, it might have to poll 20, 30, 40, or more, different city planning agencies in addition to some county agencies. In the eyes of a health planner, who works at a regional scale, urban planning appears highly fragmented, with dozens of different agencies, each with its own set of plans and ordinances and each with its own view of how the region will grow in the next 20 years. To further complicate matters, the city plans do not always agree with the plans of a regional planning body, which in turn may be in conflict with those of an independent transportation planning agency.

The health planners interviewed during the field studies have little trouble identifying urban planners, but they do have some difficulty in determining to which of the many they should listen. These health planners complain of the contradictory population estimates that emanate from various urban planning offices. In most cases, the health planners end up doing their own projections or else using figures prepared by State agencies. Similarly, there are complaints about the difficulty of finding out the location and timing of future highway construction projects. The indecision in transportation planning is at least understandable to urban planners, but health planners expect urban planners to provide them with firm answers to their questions; they fail to understand why there is so much uncertainty about planning a highway network for 1985. Their expectations are often unrealistic, but they are nonetheless real. The uncertainty they face forces them into a desparing attitude concerning the possible assistance that urban planners can give them.

THE PUBLIC PLANNER AND THE PRIVATE HEALTH SYSTEM

The fact that the investments in the health care system are overwhelmingly private has impeded, and will continue to impede, urban planning participation in health affairs. Several respondents to the questionnaire cite this as one of the principal reasons they have not been more active in health planning.

Although urban planning began under a voluntary auspices, it has evolved into an essentially governmental activity. Health plannning has not—yet. The planning undertaken by health and welfare councils and areawide health facility planning councils is essentially private or voluntary planning. The connection of these agencies with the public sector is tenuous. They usually have little influence over the public agencies concerned with large-scale health programs, and evidence the historic suspicion of government that is characteristic of much of the health industry. Health planners are oriented toward a different set of organizations and activities than are urban planners. The differences in organizational context and philosophical orientation restrict the capacity of these professionals to work together.

As the boundaries between public and private health continue to blur and as government continues to increase its investment in the health system, this problem will decline in importance. In the interim, it is reasonable to expect that urban planners will continue to turn most frequently to the agencies which share their public service perspective—the public health agencies.

CHANGING CONCEPTION OF URBAN PLANNING

Finally, the ambivalance of urban planners concerning the scope of their responsibilities weakens their capacity to respond adequately to trends in the health field. An urban planner today is both a generalist and a specialist. He is an expert in planning techniques—in techniques of goal formulation, in devising methods of attaining goals, and in testing the success of these methods—but he has limited the application of this skill to the physical aspects of the community.

Health planners are confused by this duality. They are not certain whether the urban planner is an expert planner, an expert in applying a procedure, or whether he is a physical development expert who happens to use planning methods. Some health planners ascribe responsibilities to the urban planner that he simply does not possess. They ignore the fact that the urban planner, particularly in the medium and smaller sized cities, devotes almost all of his time to problems of land and physical development. They think of him as a generalist planner concerned with the entire spectrum of public problems when in fact he usually has a much narrower range of responsibilities. Some health planners recognize themselves as functional planners—limited-purpose planners—and search in vain for a comprehensive planner—a planner that can integrate physical, social, and economic planning. In this sense of comprehensive, few urban planners can lay claim to the title. They are functional planners in the same sense that health planners are funtcional planners. One deals with the phsyical community; the other deals with the health of the community.

Urban planners and health planners do in fact assist each other in the one area in which their interests overlap—physical development. When a health program is finally grounded in a building, then the urban planner does have a clear role to play in supporting health planning. Judging from the questionnaires and interviews, he does assist health planners with their physical development programs. However, when the problems go beyond physical development, his contribution is almost nonexistent.

If the urban planner's contribution to health planning is to extend much beyond assisting with physical development problems (which is in itself an undeniably important contribution), he will have to become more like a comprehensive planner in the broadest sense of the term. Urban planning agencies are in fact expanding their responsibilities as they get into model cities programs and other interdisciplinary endeavors. Some have established social planning units and have focused their attention on problems they would not have considered five years ago, including planning for health care services and facilities. How far an agency progresses toward becoming a comprehensive planning agency will in a large measure determine the extent of its contribution to health planning.

THE PROBLEMS IN PERSPECTIVE

Although the number and size of the barriers to improved relationships between urban planners and health organizations are indeed large, it is essential to keep in mind one important offsetting factor: The pragmatism and inventiveness of practicing urban planners and health planners. These practitioners usually do not get hung up on philosophical disputes concerning the nature of planning or the boundaries of a professional discipline. They see what needs to be done and then search for ways to do it. They recognize the barriers but they are usually not immobilized by them.

This is not to suggest that there is no professional competition or organizational infighting at the local level; there obviously is. Each organization wants to maintain, if not expand, its size and influence. Each profession is wary of intrusions into its territory. But, this competitiveness and parochialism is tempered by a spirit of compromise and pragmatism that allows each to develop schemes of cooperation and attitudes of accommodation never dreamed possible by observers from afar. By a slow process of mutual adjustment that takes into account time, personalities, resources, and legislation, the practitioners are able to evolve working systems that are mutually satisfactory. Because they are comfortable with this incremental approach, an approach that depends on a personal knowledge of all that is taking place within the community, they are highly suspicious of what they consider utopian proposals for reform, whether these schemes come from Congress in the form of new legislation, from academic theoreticians, or from their own professional associations which they often consider out of touch with what is happening. The practitioners must live with each other—not with Congress, their professional associations, or the academic community. They must face each other across meeting tables, use each other's resources, and develop ways of working on problems of mutual interest. They cannot let theory impede their work.

This in no way implies that the barriers identified above are unimportant. They are extremely important, and they have clearly served to inhibit the cooperation of health planners and urban planners. The barriers cannot, however, be considered in isolation from the special circumstances that exist in each community. If the directors and policymaking boards of local organizations are imaginative and open to new ideas (variables that are difficult to quantify and therefore often ignored), then the barriers will be overcome. If they are cautious and cling to narrow professional self-definitions and the letter of the law, then the barriers will stand as explanations or excuses for inaction.

Chapter V

URBAN PLANNING AND HEALTH PLANNING: FUTURE POSSIBILITIES

Planning for the provision of community health services and facilities should occupy a more prominent place in the work of the urban planning agency. There is little disagreement over this point. Four of every five agencies surveyed readily agree that health planning has not been adequately covered in their programs; an overwhelming majority of the health personnel interviewed agree that the urban planner should be more actively involved in solving community health problems. Any exhortation to the urban planner to do more in health planning must of course be tempered by a recognition that there are substantial barriers not easily overcome, which will work against any significant increase in his participation.

Because of the barriers and because of the unsettled, undefined character of health planning, we have avoided the temptation to force what is highly complex and unstructured into a simple and structured format. We cannot offer any easy solutions; there are none. We cannot recommend a list of activities in which every urban planning agency should engage when we know that health planners are often unable to define their own objectives clearly, let alone communicate their needs to the urban planning agency. We cannot offer any simple formula on how to get along with health planners. We cannot, in good conscience, urge the urban planner to move aggressively into a field he knows little about, especially one which has already been firmly staked out by other professional groups.

As was stated in the introduction:

> The point of departure for the report is today's urban planning agency with all its strengths and weaknesses, its limited budget, its overworked staff, and its present program commitments. The question is, how can these agencies best relate to the development of comprehensive community health planning however it occurs.
>
> As a result of this pragmatic approach, the conclusions are not surprising nor the recommendations bold. The fact is, urban planning is not essential to health planning. Individual health institutions will continue to develop and improve their services and facilities. Health planning organizations will be established and will operate no matter what urban planners say or do. The role of urban planning agencies is a role of choice; in most cases, it will be a supporting role. The agencies will be contributors to the health planning process, and in many cases important and essential contributors to it, but they will not be the principal force behind the health planning movement. With the exception of some important cases, no one has asked urban planners to be health planners, nor have urban planners asked to be included in the process. No one has yet given them the money or other resources to do the work that needs doing. Health planning is low on the list of priorities for most urban planning agencies, and it will probably remain low for the next few years.

At this time, the greatest need of the average urban planning agency is to prepare itself to respond intelligently and realistically to the emergence of community health planning activities. It needs a perspective, a way of viewing itself in relationship to a trend that is still barely discernible. It needs to recognize that health is an area it has traditionally ignored, but can no longer ignore. The planning agency needs to be able to identify opportunities for collaboration, opportunities that have too often been neglected in the past. It needs to prepare itself for the difficult task of responding intelligently to a situation that is highly fluid, where experimentation is the accepted mode of practice. It needs to recognize that there are few rules for working with health planners, that, in fact, each agency will make its own rules as it goes along.

THE ROLE OF THE PLANNING AGENCY

We believe that urban planning agencies have three related roles to play in community health planning: The initiation and general support of planning activities in health organizations; the alteration of technical programs in order to contribute to the development of an improved health delivery system; and, when the opportunity arises, the undertaking of health planning activities not being performed by existing organizations. Each of these roles is discussed below, supplemented by illustrative recommendations. Some of the recommendations are quite simple and could be put into effect by a planning agency with a minimum amount of time and effort. Others are more complex and require greater commitments. In effect, the recommendations are a checklist of the kinds of things an urban planning agency might consider doing to improve its contribution to health planning and to the community's health system.

Initiate and Support Health Planning

The agency can help initiate health planning activities and can support such activities by creating an informed, supportive public and governmental attitude.

Throughout this report we have stressed the point that health planning is in an embryonic stage of development, in need of all the support it can get, both from within the health establishment and from without. The urban planning agency can be an important source of outside support.

Public Law 89–749, the comprehensive health planning law, is far too important to be ignored by the urban planning agency. Each agency should be involved in bringing the benefits of this legislation to its community. It should participate in determining who will be doing comprehensive planning as well as what will be the substance of such planning. If the health interest groups are slow to create a comprehensive health planning agency, the urban planning agency should not passively accept this situation. It should strongly encourage them to apply for a grant. It should, if necessary, help write applications for planning funds, or provide staff, office space, or other resources necessary to get an agency organized.

This responsibility cannot be taken lightly. In a substantial number of metropolitan areas there will be competition among different health organizations for the right to wear the mantle of comprehensive health planning. Various health organizations will attempt to exert influence in the selection process, to make sure that the designated agency is sympathetic to its program. The urban planning agency may be asked to endorse a particular agency, and may well find itself being courted by two or three competing groups, each trying to gather as much community support as possible. Because the agency needs to know the nature of the prize being contested and the qualifications of the contestants, it should be involved in these discussions at the earliest possible moment. The urban planning agency will have to live with the designated agency for many years and therefore should make every effort to see that is a viable organization.

> *The planning agency should seek representation on the policy-making boards and working committees of health planning organizations, particularly the comprehensive health planning agency.*

It is evident from both our case studies and questionnaire survey that when a planning agency is officially represented on a health planning organization, either its board or a committee, substantial benefits accrue to both the urban planners and the health planners. Such representation, in addition to being educational to both parties, is an effective way to share ideas and information. This kind of official, permanent contact is far preferable to vague efforts to "coordinate" or ad hoc approaches to solving problems of mutual concern.

> *The urban planning agency should actively stimulate public and governmental support for all health planning activities.*

Support for health planning by the urban planning agency should not, of course, be limited to the beginning stages; it should be an ongoing activity. An alert agency will quickly recognize the value of having professional health planners in the community and will therefore do all it can to see that these planners receive necessary support. In most areas, the urban planning agency is a well established and accepted component of the community, having gained the confidence and support of the public and of government officials. It plays an important leadership role and is looked to for advice. Because of its position within the community, the agency's attitude toward local health planning activities will in turn influence the attitude of other important individuals and groups. The urban planner, for example, is the chief spokesman on city development matters. He plays an important role in shaping policy on such things as transportation, recreation, and industrial development; in setting priorities for development activities, and in coordinating public improvement projects to harmonize the development plans and policies. If, in carrying out these activities, the urban planner is insensitive to the effect his actions will have on the health system, or if he underplays the goals of health planners, this attitude will be transmitted to city councilmen, plan commission members, the chief executive, and the general public. These individuals and groups will in turn be less responsive to the needs of the health planners. Strong and vocal support by the urban planner does not, of course, necessarily guarantee support, but it can help to establish a more aware, receptive climate for health planners in the government sector.

> *The urban planning agency should support health planning organizations by supplying them with any information, advice, and manpower that the health planners require to carry out their responsibilities.*

Providing health planning organizations with information is unquestionably the easiest form of involvement for the urban planning agency. In this capacity it can act as a source of information for any and all organizations engaged in health planning. Most agencies, for example, have substantial amounts of data available on: community population and economic trends, the transportation system, and market conditions, priority projects for government action, and so on. Such data is potentially very useful to hospitals, hospital planning councils, and other segments of the health system, but at present most health organizations do not see the urban planning agency as a major supplier of data on the community or on the health system itself. The urban planning agency should, therefore, take the initiative in investigating what kinds of data health interest groups need and, if possible, in modifying their data collection procedures or expanding them to provide better service to the health planners.

One of the main responsibilities of the urban planning agency is to collect, interpret, and present information about community and subarea growth and change. This information is essential to health planners since it describes the people and the environment to which they direct their services. Great care must be taken by the urban planner, however, to present this interpretative information in a way that will be useful for health planning purposes. Here, the urban planner must work closely with health planners to find out precisely what it is they need to know about the character of the present and future community.

Facts and figures about community growth and change are not the only types of assistance that a planning agency can supply; an agency can also be a source of information on planning techniques. The urban planner has had considerable experience with a variety of analytical tools, many of which are applicable to the health field. Small area projections and the delineation of service areas are but two of the many techniques that are applicable to both fields. In general, health planners have little knowledge or appreciation of the planning process or the techniques commonly used by the urban planner. Health planners tend to be either overly ambitious, trying to embrace highly sophisticated analytical tools that are, at present, not relevant to current needs, or else they tend to do nothing but list problems and arbitrate disputes among competing health interest groups. Various methods should be explored to determine how health planners might utilize the urban planner's experience and knowledge of the planning process. This is potentially one of the most important contributions of the urban planner; it is also one of the most difficult to make. In the long run, of course, the problem will be alleviated as health planning matures as a profession and as more universities begin training health planners. In the short run, more intensive contacts between health planners and urban planners may be advantageous. Hopefully, these contacts would enable health planners to gain a greater understanding of planning techniques and methods.

In addition to supplying information and advice, the urban planning agency can, on occasion, supply health planners with manpower. Although most urban planning agencies are understaffed, they probably have, at this time, larger staffs than the health planning groups. It is possible to use these manpower resources in many ways. This might take the form of joint study, or a special project at the request of the health planning agency. Naturally, the planning agency must view the study as important to the community; it cannot become a staff assistant on every health planning project undertaken in the community. The most effective way in which health planners and urban planners can relate to each other is through the formal and specific project. Staff meetings or other forms of informal coordination are useful but make little sense unless they are focused on a specific problem or a joint activity. It is only when the two groups formally agree to pursue a specific project that they are able to learn from and contribute to each other.

Finally, the urban planning agency is a resource in that it is a focal point, or can provide a focal point or meeting ground, for health planners. The planning agency has widespread community support which enables it to act as a coordinator and an arbitrator. When projects cut across agency boundaries the urban planning agency can be instrumental in resolving conflicts. The urban planner has traditionally thought of himself as a coordinator; increasingly he thinks of himself not only as a coordinator of government activities, but as a coordinator of all public, private, and voluntary activities that take place within his jurisdiction. Although far too many urban planning agencies fail to recognize that coordination is expensive, time consuming and complex—that is, they underestimate what it takes to coordinate effectively—as much as any group in the community the planning agency is in a position to act as a coordinator.

> ***The urban planning agency should designate one or more members of its staff to act as liaison between the agency and health planning organization.***

Too often, there is no one on a planning agency staff who has an interest in or knowledge of health planning. By designating someone to act as liaison with the health interest groups, the planning agency can improve its capacity to play a supporting role. This staff member should be encouraged to attend meetings of health planning organizations and should be responsible for seeing that all health planning organizations are fully informed of the activities of the urban planning agency and of the kinds of services the agency has to offer. This may take the form of an occasional meeting of health interest groups in which an urban planner informs them of current city problems, or it may be nothing more than making sure that the health interest groups are on the mailing list of the planning agency. At this time, only the largest agencies will be able to hire staff especially qualified for this task, but this should not prevent smaller agencies from designating someone who can at least stay abreast of current health activities. Failure to do this will seriously undercut any agency's capacity to contribute to and support local health planning efforts.

Altering the Urban Planning Program

Providing assistance and general support is a minimum contribution that an urban planning agency can make to health planning. The agency must also look at its own technical program to determine what it can do differently—often with a minimum effort—to help create a better health delivery system. In this respect, urban planning activity must be directed at: accommodating the peculiar locational requirements for space, environment, and accessibility of all types of health services; ensuring that all physical development programs influencing the location and mobility of people are compatible with schedules to provide needed health services; and creating a land-use pattern and physical environment which will encourage the achievement of health objectives. Essentially, this role means that the urban planner will have to determine how his varied technical activities can be adopted and modified to advance the goals of health planning. Specific suggestions for modification include the following.

> ***The urban planning agency should review, and if necessary revise, its community zoning ordinance to ensure that the ordinance contributes to the development of a balanced system of health facilities.***

Most city planning agencies spend considerable time on zoning problems and, although health facilities are not one of the most frequently encountered problems, it is evident that many agencies find health facilities zoning a difficult responsibility. Very large hospitals seem almost beyond zoning requirements, particularly as to their location. The availability of sufficient amounts of land is more important in determining location than is the zoning ordinance. The very largest health institutions are in many respects like large industrial complexes, and in some respects they are worse. The night and day operation of the hospital, its demands for parking, the traffic it generates, the noise of sirens, and the continuing problem of truck deliveries make large hospitals a less than desirable use. However, because the hospital is for the treatment of the ill, and not for the manufacture of products, it is frequently given favored treatment. Smaller, secondary facilities such as halfway houses and old age homes, are also particularly vexing zoning problems. Many are not appropriate for commercial areas, yet they are kept from residential areas by objecting neighbors. In addition, it is difficult to categorize the many different kinds of health facilities: nursing and convalescent homes, long-term care facilities, general hospitals, day-care treatment hospitals, mental health centers, halfway houses, and so on.

Health planners have expressed considerable concern about the effects of zoning ordinances on the health system. Often, they feel the ordinances are simply not realistic in terms of what they allow and disallow, therefore retarding the proper development of a health facilities system. The Hospital Planning Association of Southern California, in its report, "A Model Health Facility Zoning Ordinance Program," expresses its concern as follows:

> One apparent fault of zoning ordinances is the inadequacy of provisions to cope with the classification and location of various health facilities in a logical and consistent way. Overgeneralization, misuse of terminology, and gross misconceptions about the functions of these uses and their impact upon the community are common. Unfortunately, little attention has been paid to the modernization of existing legislation or the institution of new legislation in the field of health facility zoning until very recently. An adequate set of definitions and a firm locational policy covering the full range of hospitals and related health facilities are needed.

Zoning ordinances should not be used to exclude the treatment of certain types of patients. Some ordinances explicitly or implicitly make it impossible for a general hospital to treat patients suffering from mental illness or alcoholism. With the trend toward making the hospital a truly general comprehensive health facility, these kinds of exclusionary clauses are clearly antithetical to the development of a proper system of facilities.

In revising zoning ordinances it is well to keep in mind that, with the trend toward comprehensive health care, greater attention should be given to designating medical center districts. It is becoming increasingly clear that there is no such thing as an autonomous health facility. New legislation and new treatment methods make it necessary for facilities to be accessible to each other. There are many values to having a medical center district, not the least of which is the symbolic value of a health focal point in the community.

Presently, there are few zoning ordinances in the country that on the one hand adequately serve the health needs of the community, and on the other hand protect the community at large from any adverse effects of these uses. Planning agencies should act quickly to remedy this defect.

> ***The planning agency should consider the possibility of using "need" as the basis of granting or denying conditional use permits for health facilities.***

It is unfortunate, but true, that many health facilities are built unnecessarily. They are built for speculative purposes or because the promoters of the project are unaware of the need for various health uses. This overbuilding is, of course, one of the primary reasons why health facility planning councils have been flourishing during the past few years. Each unnecessary bed is an added burden for the community. Hospital planning councils have mixed feelings about how they can stop the building of unneeded facilities. Most prefer the voluntary method using persuasion or suggestion to keep people from building unneeded facilities, shying away from calling for legal authority that would enable them to stop the proposed use.

It has been suggested that all health facilities should be conditional uses under the zoning ordinance, and that the need for the facility be the prime criterion used in judging each permit application. For example, the Hospital Planning Association of Southern California recommends that "no health facility will be initiated without a conditional use permit including the prerequisite of establishing the need for such a facility." This places the planning agency and the zoning board in the position of having to judge whether a facility is needed. In most cases, neither the agency nor the board has the technical competence to make such judgments, although they could rely on an opinion from a health planning agency or a local health department.

There are a number of problems associated with this technique. Some courts, for example, might find it unconstitutional to use "need" as a consideration in granting or denying applications. It is true, however, that something analogous to this is used frequently in the case of shopping centers. A market survey showing the expected demand for a proposed center is often a requirement in any application for a permit. Although using the zoning ordinance to restrict overbuilding is a poor substitute for stricter state licensing laws or other forms of control, it is preferable to no control at all.

> *The planning agency should establish a procedure whereby all zoning matters related to health facilities are referred for review and comment to a community health planning organization.*

Regardless of whether or not "need" is a criterion used in judging applications for the development of health facilities, it would be useful for all applications related to these uses to be referred to a recognized health planning organization for comment. This should be done at the earliest possible time to allow the organization to contribute its ideas and opinions. The health organization should be asked to attend public hearings or any other meetings in which such items are discussed.

> *The planning agency should undertake a comprehensive study of the total community health facilities system, including information on linkages between facilities, site planning, accessibility, and location requirements.*

There is currently little information available on the character of a balanced community health facilities system. Most health institutions have, for a variety of reasons, been unable to think of themselves as being part of a larger system. The urban planner's expertise in the area of facility system planning qualifies him to undertake, or cosponsor, a major study in this area. Such a study would be of great assistance in revising outmoded zoning ordinances if it were able to develop criteria for determining desirable minimum lot sizes or acreages for different types of facilities, or desirable lateral distances from other structures both from the standpoint of the effect on neighboring uses and the effect on the hospital itself. A successful study of this kind would be a major step toward creating a more balanced and effective system of facilities.

> *The urban planning agency should include a health services and facilities section in its comprehensive plan.*

Although there is currently much debate concerning which constitutes a community plan, and whether or not one is necessary, most communities do strive to prepare a document that does set forth the general policies of the jurisdiction. In such a document, it would be wise to include information on health services and facilities, just as information is included on education and recreation need. A community general plan is a highly visible and well respected document and the position taken in that document concerning health could be instrumental in generating support for health planning proposals.

> *The urban planning agency should clearly inform all health institutions of the kinds of contributions the agency can make to assist them in their development planning.*

Hospitals and other major health institutions are often unaware of possible contributions an urban planning agency can make toward improving their utility. Frequently these institutions consider moving out of the city in order to escape some of the city's problems, usually an unwise use of limited regional resources. The planning agency can help institutions to break out of landlocked positions which stand in the way of immediate growth. The agency can help in acquiring land for long-range purposes as well as in the prevention and removal of blight surrounding the institution. The planning agency can replace or reroute traffic in order to alleviate some of the institution's transportation and parking problems, and can take steps to ensure an adequate housing supply for the benefit of present and future medical staff. It is the responsibility of the given planning agency to see that all health institutions are aware of the kinds of contributions the agency can make toward improved institutional development.

> *The urban planning agency should take the initiative in all community studies to see that the availability of health services is considered when evaluating neighborhood and other community areas.*

In renewal plans and other programs which require a judgment concerning the adequacy of a subarea of the city, it is important to recognize that the availability of health services is equally as important as the availability of education, or recreation or commercial services. Neighborhood plans, district plans, studies of new large-scale developments, renewal plans, and other kinds of area studies often investigate the adequacy of housing, transportation, retail services, education, and so on. Rarely do they investigate the adequacy of health services. The urban planner needs to think in terms of health services when he undertakes neighborhood and district plans far more than he has in the past.

> *The planning agency should establish a health service and facility technical advisory committee.*

If, as recommended, the urban planning agency extends its participation in health planning, it is important that the best possible advice be available from various health interest groups. The health advisory committee might not be necessary if the planning agency develops close working relationships with the broadly representative comprehensive health planning agency. On the other hand, at this time there are many divergent and competing interests in health and it could be a mistake to establish an alliance with just one health organization. An independent committee representing all major interests might be more useful. Such a committee would be most beneficial in establishing criteria for regional agencies charged with reviewing federally supported projects under title II of the Model Cities Act. The city agency would find the committtee useful for advice on zoning problems, location of neighborhood service centers, and any of the other health activities in which the agency will no doubt be involved in the future.

The Urban Planner as a Health Planner

We have stressed throughout this report that the urban planner's role is primarily supportive, one of contributing to the work of health planners. While this will be true for most planning agencies, it should not obscure the fact that in certain settings and under certain circumstances some urban planning agencies will, and should, act as critics of health planning and in some cases even act as health planners. This might occur when there is a vacuum of leadership in the health planning field or when the urban planner does not agree with the health planners. Some urban planners may not choose to be simply passive observers or occasional contributors to health planning. In effect, such a planner would openly acknowledge the obvious: Health planners have no monopoly on original ideas or creative solutions to health problems and, in fact, may be handicapped by their health perspective, which prevents them from viewing their problems from a broader vantage point. Such an activist may well find himself responsible for working out plans for the future of a county hospital or a health care program for the indigent, or acting in some other capacity as a health planner. In this role he may indeed be working at cross purposes with one or more health organizations, holding opinions contrary to those of health planners.

At present, the most urgent need is to establish a system of communication between the fields of urban planning and health planning; it is not to build individual empires. Both the urban planner and the health planner must explore opportunities for collaborative efforts. Both must be willing to experiment. If these collaborative efforts are to be successful, the urban planner must recognize his obligation to his constituents to press for decisions he thinks are in their best interest. To do otherwise—to leave health planning entirely to the health planners—is to shirk a professional responsibility.

FOOTNOTES

[1] Report of the National Advisory Commission on Health Manpower, I (Nov. 1967), 1–2.

[2] Michael Joroff, "A Significant But Limited Role," *Planning 1967*, selected papers from ASPO Conference, Houston, Apr. 1–6, 1967, p. 209.

[3] Report of the National Advisory Commission on Health Manpower, I (Nov. 1967), 33.

[4] Ibid., p. 36.

[5] National Commission on Community Health Services, *Comprehensive Health Care: A Challenge to American Communities*, Report of the Task Force on Comprehensive Personal Health Services (Washington, D.C.: Public Affairs Press, 1967), p. 17.

[6] American Medical Association, *Basic Facts About the American Medical Association * * * its purpose * * * its accomplishments* (Chicago: The Association, 1964), p. 1.

[7] George Baehr, "Prepaid Group Practice: Its Strengths and Weaknesses, and Its Future," *American Journal of Public Health*, LVI, No. 11 (Nov. 1966), 1898.

[8] National Commission on Community Health Services, *Health Is a Community Affair* (Cambridge, Mass.: Harvard University Press, 1966), p. 21.

[9] Report of the National Advisory Commission on Health Manpower, op. cit., p. 14.

[10] *Health Is a Community Affair*, op. cit., p. 84.

[11] See articles in New York Academy of Medicine, *Closing the Gaps in the Availability and Accessibility of Health Services*, report of the 1965 Health Conference (New York: The Academy, 1965).

[12] Robert H. Hamlin, "The Role of Voluntary Agencies in Meting the Health Needs of Americans," in *Health and the Community*, eds. Katz and Felton (New York: The Free Press, 1965), pp. 374–384.

[13] John J. Hanlon, *Principles of Public Health Administration* (4th ed.; St. Louis: The C. V. Mosby Co., 1964), p. 24.

[14] Ibid., pp. 339–367.

[15] Hollis S. Ingraham, "Public Health—Beyond the Crossroads," *American Journal of Public Health*, LVII, No. 5 (May 1967), 731–736.

[16] This listing has been taken from National Commission on Community Health Services, *Health Care Facilities: The Community Bridge to Effective Health Services*, report of the Task Force on Health Care Facilities (Washington, D.C.: Public Affairs Press, 1967), pp. 31 ff.

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[18] American Hospital Association, *The Changing Hospital and the AHA* (Chicago: The Association, 1965).

[19] *Health Is a Community Affair*, op. cit., p. 116.

[20] Report of the National Advisory Commission on Health Manpower, op. cit., p. 55.

[21] National Commission on Community Health Services, *Health Care Facilities*, op. cit., p. 59.

[22] See U.S. Department of Health, Education, and Welfare, *A Report to the President on Medical Care Prices* (Washington, D.C.: U.S. Government Printing Office, 1967).

[23] Ibid., pp. 19–20.

[24] Health Insurance Institute, *1966 Source Book on Health Insurance Data* (New York, 1966), pp. 5–6.

[25] Markley Roberts, "Trends in the Organization of Health Services: The Private Sector," *The Economics of Health and Medical Care*, proceedings of the Conference on the Economics of Health and Medical Care, May 10–12, 1962 (Ann Arbor: University of Michigan Press, 1964), p. 37.

[26] Robert Morris and Martin Rein, "Emerging Patterns in Community Planning," *Perspectives on the American Community*, ed. Roland L. Warren (Chicago: Rand McNally & Co., 1966), p. 418.

[27] See U.S. Department of Health, Education, and Welfare, Public Health Service, *The Role of Health and Welfare Councils in Comprehensive Community Health Planning*, Public Health Service Publication No. 1488 (June 1966).

[28] Further information may be obtained from the Office of Comprehensive Health Planning and Development, Office of the Surgeon General, Public Health Service, Bethesda, Md. 20014.

APPENDIX A

BIBLIOGRAPHY

The purpose of the bibliography is to provide the urban planner with a set of reference materials which will aid him in further understanding the health system and its planning component. All references have been selected on the basis of their usefulness to urban planning agencies.

I. The Health Care System.
  A. General Background and Major Policy Issues.
  B. Medical Manpower.
  C. Health Agencies: Public and Private.
  D. Hospitals and Health Facilities.
  E. Economics of Health.
  F. Health Legislation.
II. Health Planning.
  A. Background of Planning.
  B. Planning Theory and Methods.
  C. Health Planning Mechanisms.
III. Urban Planning and Health.
  A. Relationships.
  B. Selected Health Reports Prepared by Urban Planning Agencies.
IV. Annotated Bibliographies.
V. Journals and Periodicals.

I. THE HEALTH CARE SYSTEM

A. General Background and Major Policy Issues

International City Managers' Association. *Administration of Community Health Services.* Chicago: The Association, 1961.

This book serves as a guide for public officials on the best policies and programs in the field of public health. It deals with the significant health problems confronting the city and sets forth accepted administrative methods for getting health work done.

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The Conference focused on the paradox of progress in means of combatting disease and the inability to make these advancements available to everyone.

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The Conference dealt with the major policy decisions facing the United States in the financing and organization of health care.

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B. Medical Manpower

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The author reviews and categorizes the 1965 literature on health manpower into four parts: the need and present status of health personnel, the "need meeting" activities, the utilization of manpower, and the future trends. A reference list is included.

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C. Health Agencies: Public and Private

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This discussion of conflict between independent national voluntary agencies and federated agencies includes statistics on volume and changes in donations. The author calls for increased cooperation in face of the growing complexity of community health and welfare programs.

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II. HEALTH PLANNING

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American Hospital Association. *Manual of Hospital Planning Procedures.* Chicago: The Association, updated 1966.

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Information and statistics upon which planning agency data can be based is included as well as a profile of each planning agency including staff size, financial backing, organization, and research in progress.

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Stewart, William L. "Partnership for Planning." Extension of remarks before the National Advisory Health Council, Nov. 28, 1966. Washington, D.C.: U.S. Public Health Service.

A detailed discussion of Public Law 89–749, the Comprehensive Health Planning and Public Health Services Amendments of 1966 is followed by commentary from a number of experts.

U.S. Department of Health, Education and Welfare. Public Health Service. *Planning for Health: As They See It * * * the Role of Health and Welfare Councils in Comprehensive Community Health Planning* (PHS Pub. No. 1488). Washington, D.C.: U.S. Government Printing Office, June 1966.

This booklet summarizes the self-conceived role and function of the Health and Welfare Council as an instrument for facilitating comprehensive community health planning. It also identifies problems associated with the achievement of a comprehensive effort.

Wisowaty, Kenneth W., Charles C. Edwards and Raymond L. White. "Health Facilities Planning," *Journal of the American Medical Association.* CXC, No. 8 (Jan. 23, 1964), 752–56.

The article is a review of the voluntary hospital planning movement in which the authors enumerate goals for planning and discuss growth potential, financing, and governing of such groups. A reference list is included.

American Medical Association. *Proceedings of First National Conference on Areawide Planning,* November 28–29, 1964. Chicago: The Association, 1964.

Andrews, Mason C. *The Role of Health and Welfare Councils in Community Health Planning.* New York: United Community Funds and Councils of America, 1966.

U.S. Houses of Representatives. Committee on Labor and Public Welfare. *Report: Comprehensive Health Planning and Public Health Services Amendments of 1966.* Report No. 2271. 89th Congress, 2nd Session. Oct 13, 1966.

U.S. Senate. Committee on Interstate and Foreign Commerce. *Report: Comprehensive Health Planning and*

Public Health Services Amendments of 1966. Report No. 2271. 89th Congress, 2nd Session. Sept. 29, 1966.

III. URBAN PLANNING AND HEALTH

A. Relationships

Altschuler, Alan A. *The City Planning Process: A Political Analysis.* Ithica, N.Y.: Cornell University Press, 1965.

The first part of the critique consists of four case studies of planning in Minneapolis and St. Paul, Minn., one of which deals with the location of a major hospital facility. Building upon the case studies and upon the broad literature of American urban planning and politics, the author offers a general critique of some important city planning theory.

Davidoff, Paul. "The Role of the City Planner in Social Planning," *Proceedings of the 1964 Annual Conference of the American Institute of Planners.* Washington, D.C.: American Institute of Planners (1964), pp. 125–31.

The author suggests that city planners become more actively involved in social planning in order to correct various imbalances in society. He discusses the planner as advocate and offers suggestions for providing funds so the indigent can be represented in the planning process.

Frieden, Bernard J. "The Changing Prospects for Social Planning," *Journal of the American Institute of Planners.* XXXIII, No. 5 (Sept. 1967), 311–323.

Changing definitions of urban problems and new political commitments are likely to emphasize the redistribution of resources to disadvantaged groups as a major policy goal. These pressures are discussed as to their effect on both the content and the management of urban planning. Two major challenges are posed to the planning profession: to increase the social sensitivity of physical planning, and to extend the scope of planning beyond the physical environment.

Joroff, Michael L. "A Significant But Limited Role," *Planning 1967.* Selected Papers from the ASPO Conference, Houston, April 1–6, 1967. Chicago: ASPO, 1967.

The article discusses the role of the city planner in health facility planning. This role is seen as limited but significant. It must be carefully explained and actively advocated to the health profession.

Herman, Harold. "Converging Interests in Health and Comprehensive Planning," *Planning 1967.* Selected Papers from the ASPO Conference, Houston, April 1–6, 1967. Chicago: ASPO, 1967.

The author discusses the potentials for coordination contained in two federal enactments—the Comprehensive Health Planning and Public Health Services Amendments of 1966 and the Metropolitan Development Act. He concludes that city planners will have to pay more attention to measures and sources of information on qualitative aspects of the community as well as its present and projected population.

Herman, Harold and Michael Joroff. "Planning Health Services for New Towns," *American Journal of Public Health.* LVII, No. 4 (April 1967), 633–40.

The creation of new towns in the United States has raised the question of planning and organizing health services for such communities. Specific efforts to achieve this end must come from the public health profession in partnership with local and state government. The principles involved and the methods by which they are implemented are discussed.

Olsson, David E. "The Planning Official and Health Facilities," *Planning 1964.* Selected papers from ASPO Conference, Boston, April 5–9, 1964. Chicago: ASPO, 1964.

The author is administrator of San Jose Hospital, San Jose, Calif. He discusses the relation of health planning to total community planning. In doing so, he presents three major deficiencies of health facility planning efforts: the narrow scope of planning, the lack of support for planning, and weak hospital boards.

Perloff, Harvey. "New Directions in Social Planning," *Journal of the American Institute of Planners.* XXXI, No. 4 (Nov. 1965), 297–304.

The author suggests an organizational structure of joint governmental and voluntary planning, and he lists the main features of the social planning process.

Cousin, Jacques. "Community Approach to Hospital Planning," *Hospitals.* XXXVI, No. 15 (Aug. 1962), 49–51.

Goerke, L. S. "The Relationship of Health Agencies and Planning Agencies," *American Journal of Public Health.* LIV, No. 5 (May 1964), 713–20.

Harmon, A. J. "Health and Urban Development: The Trends and Probable Future of Cities in Relation to Health," *American Journal of Public Health.* LIV. No. 5 (May 1964), 699–703.

Perloff, Harvey S. "Pomeroy Memorial Lecture: Common Goals and the Linking of Physical and Social Planning." *Planning 1965.* Chicago: ASPO (1965), pp. 170–84.

Webber, Melvin M. "Comprehensive Planning and Social Responsibility: Toward and AIP Consensus on the Profession's Roles and Purposes," *Journal of the American Institute of Planners.* XXI, No. 4 (Nov. 1963), 232–41.

Wood, Elizabeth. *Social Planning: A Primer for Urbanists.* Brooklyn: Pratt Institute, 1965.

———. "Social Welfare Planning," *The Annals of the American Academy of Political and Social Science.* CCCLII (March 1964), 119–28.

B. Selected Health Reports Prepared by Urban Planning Agencies

Health Facilities in Herkimer-Oneida Counties. Utica, N.Y.: Herkimer-Oneida Counties Comprehensive Planning Program, 1966.

Health and Welfare Facilities: An Inventory. Lansing Mich.: Tri-County Regional Planning Commission, 1964.

Hospital Study for Prince George's County Maryland. Silver Spring, Md.: Maryland National Capital Park and Planning Commission, 1965.

Kaplan, Ethan Z. *A Guide for an Appropriate Nursing Home Facility.* St. Louis County, Mo.: St. Louis County Planning Commission, 1963.

Medical Center Hill: A District Plan for the Growth and Development of "Pill Hill." Oakland, Calif.: City Planning Department, 1959.

The Medical Center District: Planning Analysis and Recommendations. Chicago: City Plan Commission, 1956.

Pinellas County Health Center Site Evaluation. Clearwater, Fla.: Pinellas County Planning and Zoning Department, 1965.

A Plan for the Hospital Complex: A Part of the Avondale Corryville Urban Renewal Area. Cincinnati: City Planning Commission, 1964.

Proposed Montgomery County Medical Complex: Preliminary Feasibility Study. Silver Spring, Md.: Maryland National Capital Park and Planning Commission, 1967.

Responsibilities of the City and County of Denver for Providing Hospital Treatment. Denver: City Planning Office, 1962.

IV. ANNOTATED BIBLIOGRAPHIES

Detloff, Virginia, Daniel L. Drosness and Nancy Ribak. *Utilization of Health Facilities and Services, 1950–63: An Annotated Selected Bibliography.* Berkeley, Calif.: The State of California, Department of Public Health, 1963.

This document embraces medical care and hospital administration as substantive fields of practice. It also includes material reflecting disciplinary contributions in such subjects as sociology, economics, demography, city and regional planning, public administration, and operations research, where the publications contain specific application to health.

U.S. Public Health Service, Community Health Service. *Comprehensive Health Planning—A Selected Annotated Bibliography,* Publication Number 17753, February 1968.

V. JOURNALS AND PERIODICALS

American Journal of Public Health. Official monthly publication of the American Public Health Association, Inc., 1790 Broadway, New York, N.Y. 10019.

Blue Cross Reports. Published quarterly by the Blue Cross Association, 840 North Lake Shore Drive, Chicago, Ill. 60611. Periodical review of research and statistics in the health field.

Bulletin of the New York Academy of Medicine. Monthly publication of the New York Academy of Medicine, 2 East 103d Street, New York, N.Y. 10029. (December issue contains the proceedings of the Academy's annual health conference.)

Community. Published bimonthly by the United Community Funds and Councils of America, Inc., 345 E. 46th Street, New York, N.Y. 10017.

Community Mental Health Journal. Published quarterly by the South Shore Mental Health Center, 12 Dimmock Street, Quincy, Mass. 02169.

Health, Education and Welfare Indicators. Published monthly by the U.S. Department of Health, Education, and Welfare. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Hospitals. Journal of the American Hospital Association. Published the first and sixteenth of each month by the Association, 840 North Lake Shore Drive, Chicago, Ill. 60611.

Journal of the American Institute of Planners. Published bimonthly in January, March, May, July, September, and November by the American Institute of Planners, 917 Fifteenth St. NW., Washington, D.C. 20005.

Journal of the American Medical Association. Published weekly by the American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Medical Care Review. Published monthly, except September, by the Bureau of Public Health Economics, School of Public Health, the University of Michigan. School of Public Health, Room 3533, University of Michigan, Ann Arbor, Mich. 48104. Contains abstracts of recent articles in public health economics and medical care.

Mental Hospitals. Published monthly by the American Psychiatric Association, 1700 18th Street NW., Washington, D.C. 20009.

Mental Hygiene. Published quarterly by the National Association for Mental Health, Inc., 10 Columbus Circle, New York, N.Y. 10019.

Public Health Reports. Published monthly by the U.S. Public Health Service. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Social Security Bulletin. Published monthly by the U.S. Social Security Administration. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

APPENDIX B

SELECTED HEALTH ORGANIZATIONS: NATIONAL AND REGIONAL*

This listing of national and regional health agencies is designed to provide reference points for the urban planner in his search for health-related information and guidance. Additional information may also be obtained from state and local health departments and voluntary health organizations.

American Association for Hospital Planning. Verne Pangborn, pres.; Dale Jennerjohn, sec.; State Board of Health, 1 W. Wilson St., Madison, Wis. 53701; tel. (608) 266–1511.

American Association of Homes for the Aging. Thomas M. Jenkins, pres.; Lester Davis, exec. dir.; 315 Park Ave., S., New York, N.Y. 10010; tel. (212) 777–1900.

American Association of Hospital Consultants. Eugene D. Rosenfeld, M.D., pres.; Frank C. Sutton, M.D., sec.-treas.; One Wyoming St., Dayton, Ohio 45409; tel. (513) 223–6192, ext. 420.

American Association of Medical Clinics. Jere W. Annis, M.D., pres.; Edwin P. Jordan, M.D., exec. dir.; Box 58, Charlottesville, Va. 22902; tel. (703) 293–4733.

American College of Hospital Administrators. Donald W. Cordes, pres.; Richard J. Stull, exec. vice pres.; 840 N. Lake Shore Dr., Chicago, Ill. 60611; tel. (312) 943–0544.

American Hospital Association. George E. Cartmill, pres.; David B. Wilson, M.D., pres.-elect; Edwin L. Crosby, M.D., exec. vice pres. & dir.; 840 N. Lake Shore Dr., Chicago, Ill. 60611; tel (312) 645–9400. New York Office: 99 Park Ave., New York, N.Y. 10016; tel. (212) 867–0311. Southeastern Office: 3379 Peachtree Road, N.E., Atlanta, Ga. 30326; tel. (404) 231–8341. Washington Office: One Farragut Square South, Washington D.C. 20006; tel. (202) 393–6066. Western Office: 601 California St., Room 1214, San Francisco, Calif. 94108; tel. (415) 981–8187.

American Institute of Architects. Robert L. Durham, pres.; William H. Sheick, exec. dir.; 1735 New York Ave. NW., Washington, D.C. 20006; tel. (202) 393–7050.

American Medical Association. Dwight L. Wilbur, M.D., pres.; 535 N. Dearborn St., Chicago, Ill. 60610; tel. (312) 527–1500.

American Nurses' Association, Inc., Jo Eleanor Elliott, R.N., pres.; Judith G. Whitaker, R.N., exec. vice pres.; 10 Columbus Circle, New York, N.Y. 10019; tel. (212) 582–7230.

American Nursing Home Association. Ed. Walker, pres.; Alfred S. Ercolano, exec. dir.; 1101 17th St., N.W., Washington, D.C. 20036; tel. (202) 296–5636.

American Protestant Hospital Association. Merton E. Knisely, pres.; John C. Eller, exec. dir.; 840 N. Lake Shore Drive, Chicago, Ill. 60611; tel. (312) 944–2814.

American Public Health Association, Inc. Milton Terris, M.D., pres.; Berwyn F. Mattison, M.D., exec. dir.; 1790 Broadway, New York, N.Y. 10019; tel. (212) 245–8000.

American Public Welfare Association. Fedele F. Fauri, pres.; Carl K. Schmidt, staff assoc.; 1313 E. 60th St., Chicago, Ill. 60637; tel. (312) 324–3400.

Association of American Medical Colleges. William N. Hubbard, Jr., M.D., pres.; Robert C. Berson, M.D., exec. director.; 2530 Ridge Ave., Evanston, Ill. 60621; tel. (312) 328–9505.

Association of Hospital and Institution Libraries of the American Library Association. Marion Vedder, pres.; Eleanor Phinney, exec. sec.; 50 Huron St., Chicago, Ill. 60611; tel. (312) 944–6780.

Association of Rehabilitation Centers, Inc. Charles L. Roberts, exec. dir.; 828 Davis St., Evanston, Ill. 60201; tel. (312) 869–0390.

Association of State and Territorial Health Officers. J. E. Peavey, M.D., pres.; Terrell O. Carver, M.D., sec. treas.; Michigan Department of Public Health, 3500 N. Logan St., Lansing, Mich. 48914; tel. (517) 373–1321.

Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities. William F. Henderson, exec. sec.; North Carolina Medical Care Commission, Box 9594, Raleigh, N.C.

Blue Cross Association, Inc. Walter J. McNerney, pres.; George Heitler, vice pres.-sec.; 840 N. Lake Shore Drive, Chicago, Ill. 60611; tel. (312) 664–2457.

Catholic Hospital Association. (Formerly, Catholic Hospital Association of the United States and Canada.) Sister Mary Brigh, O.S.F., pres.; Rev. John J. Flanagan, exec. dir.; 1438 S. Grand Blvd., St. Louis, Mo. 63104; tel. (314) 773–0646.

Center For Health Administration Studies. George Bugbee, dir.; 5720 S. Woodlawn Ave., Chicago, Ill. 60637; tel. (312) 667–1055.

Council of Jewish Federation and Welfare Funds, Inc. Lewis H. Weinstein, pres.; Philip Bernstein, exec. dir.; 315 Park Ave South, New York, N.Y. 10010; tel. (212) 673–8200.

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*A complete listing of international, national, regional, and state organizations is contained in the "Guide Issue" of *Hospitals: Journal of the American Hospital Association,* issued in August of each year.

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES. Rheet McMahon, M.D., pres.; M. H. Crabb, M.D., sec.; 1707 Medical Arts Bldg., Fort Worth, Tex. 76102; tel. (817) 335–1141.

GROUP HEALTH ASSOCIATION OF AMERICA. Lorin Kerr, M.D., pres.; W. Palmer Dearing, M.D., exec. dir.; 1321 14th St., N.W., Washington, D.C. 20005; tel. (202) 332–3820.

HEALTH INSURANCE COUNCIL. L. A. Orsini, dir.; 750 Third Ave., New York, N.Y. 10017; tel. (212) 986–8866.

HEALTH LAW CENTER—UNIVERSITY OF PITTSBURGH. John F. Horty, dir.; 130 De Soto St., Pittsburgh, Pa. 15213; tel. (412) 683–1620, ext. 2132.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS. John D. Porterfield III, M.D., dir.; 645 N. Michigan Ave., Chicago, Ill. 60611; tel. (312) 642–6061.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC. Brian O'Connell, exec. dir.; 10 Columbus Circle, New York, N.Y. 10019; tel. (212) 757–7800.

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS. J. W. Castellucci, pres.; 211 East Chicago Ave., Chicago, Ill. 60611; tel. (312) 943–8181.

NATIONAL HEALTH COUNCIL. J. Douglas Colman, pres.; Peter G. Meek, exec. dir.; 1790 Broadway, New York, N.Y. 10019; tel. (212) 245–8000.

NATIONAL LEAGUE FOR NURSING, INC. Lois M. Austin, Ph. D., chrm.; Inez Haynes, R.N., gen. dir.; 10 Columbus Circle, New York, N.Y. 10019; tel. (212) 582–1022.

NATIONAL MEDICAL ASSOCIATION. John L. S. Holloman, Jr., M.D., pres.; Samuel C. Smith, sec.; 520 W. St., N.W., Washington, D.C. 20001; tel. (202) 232–1604.

NEW YORK ACADEMY OF MEDICINE. Two East 103rd St., New York, N.Y. 10029.

UNITED COMMUNITY FUNDS AND COUNCILS OF AMERICA, INC. Joseph A. Beirne, pres.; Lyman S. Ford, exec. dir.; 345 E. 46th St., New York, N.Y. 10017; tel. (212) 687–8300.

UNITED STATES CONFERENCE OF CITY HEALTH OFFICERS. 1707 H St., N.W., Washington, D.C. 20006.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; PUBLIC HEALTH SERVICE: Office of the Surgeon General: William H. Stewart, M.D., 330 Independence Avenue, Washington, D.C. 20201.

WORLD HEALTH ORGANIZATION. M. G. Candau, M.D., dir.-gen.; Palais des Nations, Geneva, Switzerland; tel. Geneva 33–10–00. Regional Office for the Americas, Dr. Abraham Horowitz, dir.; Pan American Health Organization, 525 23rd St., N.W., Washington, D.C. 20037; tel. (202) 223–4700.

APPENDIX C

Appendix Table 1.—*Population and jurisdictional distribution of agencies responding to questionnaire*

Population group	City agencies	County agencies	Combined agencies [1]	Total
Over 500,000	17	18	17	52
250,000 to 500,000	15	15	10	40
100,000 to 249,999	40	15	12	67
Under 100,000	40	5	0	45
Totals	112	53	39	204

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

Appendix Table 2.—*Planning agency involvement in planning for health services and facilities—By jurisdiction*

Extent of involvement	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies (n=204)	Percent of total	Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies [1] (n=39)	Percent of total
Percent of agency's time spent on health planning during past 2 years:								
Less than 2 percent	169	82. 8	94	83. 9	44	83. 0	31	79. 5
3 to 5 percent	30	14. 7	15	13. 4	8	15. 1	7	17. 9
6 to 15 percent	3	1. 5	1	0. 9	1	1. 9	1	2. 6
No Response	2	1. 0						
Planning agency has been encouraged by health organizations to take a more active role in health planning	48	23. 5	16	14. 3	16	30. 2	16	41. 0
Planning agency's involvement in health planning has been or would be resisted by health organizations	38	18. 7	22	19. 6	5	9. 4	11	28. 2
Planning agency has staff members who are particularly interested in health planning	57	27. 9	23	20. 5	17	32. 1	17	43. 6
Planning agency has staff members who have had training and/or experience in health planning	8	3. 9	5	4. 5	1	1. 9	2	5. 1

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

Appendix Table 3.—*Planning agency involvement in planning for health services and facilities—By population group*

Extent of involvement	Number and percent of agencies replying affirmatively—Agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Percent of agency's time spent on health planning during past 2 years:								
Less than 2 percent	41	78. 8	27	67. 5	58	86. 6	43	95. 6
3 to 5 percent	10	19. 2	11	27. 5	7	10. 4	2	4. 4
6 to 15 percent	1	1. 9	1	2. 5	1	1. 5	0	--------
Planning agency has been encouraged by health organizations to take a more active role in health planning	21	40. 4	11	27. 5	10	15. 0	6	13. 3
Planning agency's involvement in health planning has been or would be resisted by health organizations	13	21 0	4	10. 0	11	16. 4	10	22. 2
Planning agency has staff members who are particularly interested in health planning	23	44. 2	13	32. 5	17	25. 4	4	8. 9
Planning agency has staff members who have had training and/or experience in health planning	3	5. 8	0	--------	3	4. 5	2	. 44

APPENDIX TABLE 4.—*Health organizations operating within the jurisdiction of the planning agency—By jurisdiction*

Health planning organizations	Number of agencies reporting a health organization			
	Number of agencies (n=204)	Agency jurisdiction		
		City agencies (n=112)	County agencies (n=53)	Combined[1] agencies (n=39)
(*a*) Areawide hospital or health facilities planning council	127	64	41	22
(*b*) Health council, health and welfare council, council of social agencies	148	82	34	32
(*c*) State or county medical society	156	81	42	33
(*d*) Local health department: city, county, or city-county	193	105	50	38
(*e*) State hospital and medical facilities agency (Hill-Burton agency)	118	58	34	26
(*f*) Local mental health planning council	113	51	37	25
(*g*) Other[2]	77	36	24	17

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

[2] Including State health departments or committees, individual hospitals and hospital boards, hospital associations, hospital districts of commissions, and county welfare boards.

APPENDIX TABLE 5.—*Health organizations operating within the jurisdiction of the planning agency—By population group*

Health planning organizations	Number of agencies reporting a health organization				
	Number of agencies (n=204)	Agency population			
		Over 500,000 (n=52)	250,000–500,000 (n=40)	100,000–249,999 (n=67)	Under 100,000 (n=45)
(*a*) Areawide hospital or health facilities planning council	127	43	27	36	21
(*b*) Health council, health and welfare council, council of social agencies	148	43	34	47	24
(*c*) State or county medical society	156	44	33	51	28
(*d*) Local health department: city, county, or city-county	193	50	38	64	41
(*e*) State hospital and medical facilities agency (Hill-Burton agency)	118	36	25	37	20
(*f*) Local mental health planning council	113	31	25	41	16
(*g*) Other[1]	77	23	13	25	16

[1] Including State health departments or committees, individual hospitals and hospital boards, hospital associations, hospital districts or commissions, and county welfare boards.

APPENDIX TABLE 6.—*Organizational relationships between planning agencies and health planning organizations—By jurisdiction*

Organizational relationships	Number and percent of agencies replying affirmatively							
	Number of agencies (n=204)	Percent of total	Agency jurisdiction					
			Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies[1] (n=39)	Percent of total
Planning agency member serves on board, commission or committee of health organization	52	25.4	13	11.6	17	32.0	22	56.4
Planning agency staff members meet with staff of health organizations	162	79.0	80	71.4	44	83.0	38	97.4
Planning agency has technical advisory committee on health	20	9.8	5	4.5	9	17.0	6	15.4

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

Appendix Table 7.—*Organizational relationships between planning agencies and health planning organizations—By population group*

Organizational relationships	Number and percent of agencies replying affirmatively—agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Planning agency member serves on board, commission or committee of health organization	18	34.6	14	26.9	16	23.9	4	8.9
Planning agency staff members meet with staff of health organizations	49	94.2	33	82.5	55	82.1	25	55.5
Planning agency has technical advisory committee on health	8	15.4	6	15.0	3	4.5	3	6.7

Appendix Table 8.—*Organizational relationships between planning agencies and health planning organizations—By health organization* [1]

Organizational relationships	Health organizations (number of planning agencies indicating a particular contact with one of the health organizations)						
	(a)	(b)	(c)	(d)	(e)	(f)	(g)
Planning agency member serves on board, commission or committee of health organization	19	23	6	4	4	6	8
Staff members meet with staff of health organizations:							
More than 3 times a year	36	57	4	102	10	8	15
Less than 3 times a year	31	28	23	35	17	19	29
Health organization represented on planning agency's technical advisory committee	11	6	1	12	5	0	1

[1] Number of agencies reporting existence of health organizations:
- (a) Areawide hospital or health facilities planning council: 127.
- (b) Health council, health and welfare council, council of social agencies: 148.
- (c) State or county medical society: 156.
- (d) Local health department: city, county or city-county: 193.
- (e) State hospital and medical facilities agency (Hill-Burton agency): 118.
- (f) Local mental health planning council: 113.
- (g) Other: 77.

Appendix Table 9.—*Exchange of information between planning agencies and health planning organizations—By jurisdiction*

Publications and Data	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies (n=204)	Percent of total	Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies [1] (n=39)	Percent of total
Planning agency sends its publications to health organization(s)	159	77.9	78	90.6	48	90.6	33	84.6
Health organizations send their publications to planning agency	154	75.5	78	69.6	45	84.9	31	79.5
Planning agency requests data from health organization(s)	146	71.6	78	69.6	37	69.8	31	79.5
Health organization(s) request data from planning agency	172	84.0	86	76.8	48	90.6	38	97.4

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

APPENDIX 10.—*Exchange of information between planning agencies and health planning organizations—By population group*

Relationships	Number and percent of agencies replying affirmatively—agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Planning agency sends its publications to health organization(s)	49	94.2	34	85.0	51	76.1	25	55.5
Health organizations send their publications to planning agency	49	94.2	31	75.5	47	70.1	27	60.0
Planning agency requests data from health organization(s)	41	78.8	32	80.0	48	71.6	25	55.5
Health organization(s) request data from planning agency	50	96.0	36	90.0	56	83.6	30	66.7

APPENDIX 11.—*Exchange of information between planning agencies and health planning organizations—By health organization* [1]

Publications and data	Health organizations (number of planning agencies indicating a particular contact with one of the health organizations)						
	(a)	(b)	(c)	(d)	(e)	(f)	(g)
Health organizations receiving planning agency publications:							
On regular mailing list	24	44	7	77	12	10	13
Particular publications	34	48	18	80	17	17	22
Health organizations sending publications to planning offices	63	78	10	103	233	16	22
Health organizations from which planning agency has requested data	50	45	9	96	26	4	20
Health organizations requesting data from planning agency	69	86	13	122	23	29	29

[1] Number of agencies reporting existence of health organizations:
(a) Areawide hospital or health facilities planning council: 127.
(b) Health council, health and welfare council, council of social agencies: 148.
(c) State or county medical society: 156.
(d) Local health department: city, county or city-county: 193.
(e) State hospital and medical facilities agency (Hill-Burton agency): 118.
(f) Local mental health planning council: 113.
(g) Other: 77.

APPENDIX TABLE 12.—*Availability of data on the health care system*

(*Summary of responses from the 204 planning agencies*)

Health care data	The information is immediately available in our offices	We know the information has been collected and we could obtain it within a few days	We do not know if the information has been collected
Location of various types of hospital services, e.g., surgery, maternity	41	115	44
Number of short term hospital beds that meet AHA-AMA accreditation standards	29	120	49
Occupancy rates at short term hospitals	23	112	61
Location and number of nursing home beds	32	112	56
Acres of land used by health care facilities	53	65	77
Location of physicians, by specialty	9	87	101
Total medical and paramedical employment	9	83	98
Wages and salaries paid to medical and paramedical personnel	1	67	125
Annual personal health expenditures	3	37	152
Indices of personal health problems in different sections of the community	9	63	121
Annual capital expenditures for health facilities	15	72	105
Residential location of patients using major health facilities	6	38	150
Mode of transportation of different socio-economic groups to health facilities	8	25	162
Incidence of diseases (e.g., TB, VD, etc.) by community subareas	27	99	66

APPENDIX TABLE 13.—*Plan and proposal review—By jurisdiction*

Plan and proposal review	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies (n=204)	Percent of total	Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies[1] (n=39)	Percent of total
Individual medical institution asks planning agency for advice and assistance	140	68.6	75	67.0	31	58.5	34	87.2
Planning agency asks health organization to review its studies	117	57.4	57	50.9	32	60.4	28	71.8
Planning agency asks health organization to review petitions for zoning changes	87	42.6	41	36.6	24	49.0	20	51.3
Health organization asks planning agency to review plans and studies	92	45.0	44	39.3	24	45.3	24	61.5

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

APPENDIX TABLE 14.—*Plan and proposal review—By population group*

Plan and proposal review	Number and percent of agencies replying affirmatively—Agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Individual medical institution asks planning agency for advice and assistance	38	73.1	24	60.0	49	43.3	29	64.4
Planning agency asks health organization to review its studies	32	61.5	25	62.5	42	62.7	18	40.0
Planning agency asks health organization to review petitions for zoning changes	21	40.4	19	47.5	28	41.8	19	42.2
Health organization asks planning agency to review plans and studies	35	67.0	17	42.5	29	43.3	11	24.4

APPENDIX TABLE 15.—*Plan and proposal review—By health organization*[1]

Plan and proposal review	Health organizations (number of planning agencies indicating a particular contact with one of the health organizations)						
	(a)	(b)	(c)	(d)	(e)	(f)	(g)
Health organizations review planning agency studies	29	32	8	96	13	5	22
Health organizations review zoning amendment petitions:							
Regularly	7	4	0	28	7	0	2
Occasionally	14	2	5	37	4	0	6
Health organizations request planning agency to review health plans and studies	33	37	5	54	9	10	13

[1] Number of agencies reporting existence of health organizations:
(a) Areawide hospital or health facilities planning council: 127.
(b) Health council, health and welfare council, council of social agencies: 148.
(c) State or county medical society: 156.
(d) Local health department: city, county or city-county: 193.
(e) State hospital and medical facilities agency (Hill-Burton agency): 118.
(f) Local mental health planning council: 113.
(g) Other: 77.

APPENDIX TABLE 16.—*Health care services and facilities and the general plan—By jurisdiction*

Health care and the general plan	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies [1] (n=93)	Percent of total	Number of city agencies (n=47)	Percent of total	Number of county agencies (n=29)	Percent of total	Number of combined agencies [2] (n=17)	Percent of total
Items included in the health section of the plan include descriptions of and/or recommendations for:								
Publicly owned health care facilities	76	81. 7	35	74. 5	25	86. 2	16	94. 1
Privately owned health care facilities	62	66. 7	31	65. 9	15	51. 7	16	94. 1
Public health care services	34	36. 6	18	38. 3	9	31. 0	7	41. 2
Private health care services	16	17. 2	8	17. 0	4	13. 8	4	23. 5
Plan recommends creation of organization to study areawide health needs	15	16. 1	5	10. 6	5	17. 2	5	29. 4
Section in general plan is, or will be, based primarily on plans of one or more of the health organizations [3]	49	52. 7	25	53. 2	13	34. 8	11	64. 7

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[1] 93 agencies have a general plan containing a health care section.

[2] Includes metropolitan, regional, and other multijurisdictional agencies.

[3] Including areawide hospital or health facilities planning council; local health department; health council, health and welfare council; State Hill-Burton agency.

APPENDIX TABLE 17.—*Health care services and facilities and the general plan—By population group*

Health care and the general plan	Number and percent of agencies replying affirmatively—agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=31)	Percent of total	Number under 100,000 (n=20)	Percent of total
Items included in the health section of the plan include descriptions of and/or recommendations for:								
Publicly owned health care facilities	23	85. 2	15	100. 0	22	71. 0	16	80. 0
Privately owned health care facilities	18	66. 7	12	80. 0	18	58. 1	14	70. 0
Public health care services	8	29. 6	4	26. 7	15	48. 4	7	35. 0
Private health care services	3	11. 1	3	20. 0	7	22. 6	3	15. 0
Plan recommends creation of organization to study areawide health needs	5	18. 5	4	26. 7	5	16. 1	1	5. 0
Section in general plan is, or will be, based primarily on plans of one or more of the health organizations [1]	21	77. 8	7	46. 7	11	35. 5	10	50. 0

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[1] Including areawide hospital or health facilities planning council; local heath department; health council, health and welfare council; State Hill-Burton agency.

APPENDIX TABLE 18.—*Information included in the general plan* [1]

	Medical schools, nursing schools, and other training facilities	Rehabilitation centers	Community mental health centers or mental hospitals	Individual professional offices (e.g., doctors, dentists, etc.)	Public health care centers or clinics	Private outpatient clinics or medical arts buildings	Nursing homes or other long-term care facilities	City or county hospital	Private, short-term general hospitals
Description of the function of each facility	23	18	29	17	37	11	21	47	37
Map showing the location of each facility	33	28	36	21	50	19	31	71	57
Existing capacity	22	16	25	9	25	9	23	50	49
Recommended ratio of beds/population	11	11	18	7	17	5	18	34	26
Recommended occupancy ratio (percent beds occupied)	7	9	7	6	10	4	13	20	13
Total number of new facilities needed	9	14	19	7	19	6	16	45	32
Locational criteria for new facilities (e.g., near commercial area, etc.)	17	17	28	19	33	15	29	49	37
Site development standards for new facilities (e.g., acres/bed, parking spaces needed for each professional office, etc.)	21	24	33	26	36	24	33	45	36

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[1] Summary of responses from the 93 agencies including a section on health in their general plan.

APPENDIX TABLE 19.—*The planning agency and Federal health legislation—By jurisdiction*

Federal health legislation	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies (n=204)	Percent of total	Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies [1] (n=39)	Percent of total
Planning agencies involved in development of health centers under the neighborhood facilities section of the Housing and Urban Development Act of 1965 [2]	64	31.4	46	41.1	8	15.1	10	25.6
Planning agency involved in efforts to determine impact of "medicare" in locality	21	10.3	12	10.7	4	7.5	5	12.8
Planning agency is familiar with the provisions of the Community Mental Health Centers Act of 1963	48	23.5	19	17.0	17	32.1	12	30.8

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[1] Includes metropolitan, regional, and other multijurisdictional agencies.
[2] A total of 77 communities of those questioned plan to build such centers.

APPENDIX TABLE 20.—*The planning agency and Federal health legislation—By population group* [1]

Federal health legislation	Number and percent of agencies replying affirmatively—agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Planning agencies involved in development of health centers under the neighborhood facilities section of the Housing and Urban Development Act of 1965 [2]	21	40.4	13	32.5	20	29.9	10	22.2
Planning agencies involved in efforts to determine impact of medicare in locality	7	13.5	10	25.0	4	6.0	0	--------
Planning agency is familiar with the provisions of the Community Mental Health Centers Act of 1963	16	30.8	12	30.0	14	20.9	6	13.3

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[1] Includes metropolitan, regional, and other multijurisdictional agencies.
[2] A total of 77 communities of those questioned plan to build such centers.

Appendix Table 21.—*Reasons why health has not been adequately covered in the planning program—By jurisdiction*

Opinions on planning agency involvement	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies (n=204)	Percent of total	Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies [1] (n=39)	Percent of total
Agency feels that planning for health care services has not been adequately covered in their planning program	159	78.0	80	71.4	43	81.1	32	82.0
Reasons planning agency has not given more attention to health care planning:								
Not enough staff	119	58.3	63	56.3	30	56.6	26	66.7
Other studies have higher priority	97	47.5	55	49.1	23	43.4	19	48.7
The health organizations are doing an adequate job	85	41.7	47	42.0	22	41.5	16	41.0
Lack of technical competence	72	34.4	42	37.5	20	37.7	10	25.6
Planners do not have a role to play in this field	15	10.5	14	12.5	1	1.9	0	--------
Other	28	13.7	12	10.7	11	20.8	5	12.8

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

Appendix Table 22.—*Reasons why health has not been adequately covered in the planning program—By population group*

Opinions on planning agency involvement	Number and percent of agencies replying affirmatively—Agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Agency feels that planning for health care services has not been adequately covered in their planning program	36	69.2	32	80.0	48	71.6	39	86.7
Reasons planning agency has not given more attention to health care planning:								
Not enough staff	30	57.7	24	60.0	43	65.7	22	50.0
Other studies have higher priority	24	46.2	21	52.5	30	43.3	22	50.0
The health organizations are doing an adequate job	24	46.2	17	42.5	27	40.3	17	38.6
Lack of technical competence	19	36.5	10	25.0	26	38.8	17	38.6
Planners do not have a role to play in this field	3	5.8	4	10.0	2	3.0	6	13.6
Other	4	7.7	6	15.0	14	19.4	5	11.4

APPENDIX TABLE 23.—*Planning agency attitudes concerning planning for health care services and facilities—By jurisdiction*

Attitudes and opinions	Number and percent of agencies replying affirmatively							
			Agency jurisdiction					
	Number of agencies (n=204)	Percent of total	Number of city agencies (n=112)	Percent of total	Number of county agencies (n=53)	Percent of total	Number of combined agencies[1] (n=39)	Percent of total
Activities in which planning agencies should be involved:								
Advising public health agencies	174	85.3	92	82.1	44	83.0	38	97.4
Reviewing petitions for zoning amendments for health care facilities	170	83.3	94	83.9	42	79.2	34	87.2
Advising private, voluntary organizations	168	82.3	90	80.3	42	79.2	36	92.3
Reviewing proposals for new health facilities	146	71.6	78	69.6	36	67.9	32	82.0
Preparing a section on health for the general plan	119	58.3	68	60.7	28	52.8	23	59.0
Making a comprehensive study of health facilities	74	36.3	37	33.0	20	37.7	17	43.6
Preparing site plans for medical centers	51	25.0	29	29.9	12	22.6	10	25.6
The attitudes of the agencies concerning their involvement in health care planning during the next few years:								
Our present level of involvement is adequate	30	14.7	20	17.8	4	7.5	6	15.4
We would like to play a more active role, but will not:								
Because of budgetary limitations	82	40.2	46	41.1	20	37.7	16	41.0
Because of lack of encouragement from the planning commission and city officials	31	15.2	14	12.5	12	22.6	5	12.8
Because the health organizations will discourage involvement	17	8.3	11	9.8	2	3.8	4	10.2
We have plans for expanding our role in this area[2]	49	24.0	20	17.8	12	22.6	17	43.7
No opinion	43	21.1	24	21.4	15	28.3	5	12.8

[1] Includes metropolitan, regional, and other multijurisdictional agencies.

[2] Examples of means of expansion include general plan studies, CRP studies, demonstration cities grants, zoning ordinance review, and the establishment of closer ties with health planning agencies.

APPENDIX TABLE 24.—*Planning agency attitudes concerning planning for health care services and facilities—By population group*

Attitudes and opinions	Number and percent of agencies replying affirmatively—agency population							
	Number over 500,000 (n=52)	Percent of total	Number 250,000–500,000 (n=40)	Percent of total	Number 100,000–249,999 (n=67)	Percent of total	Number under 100,000 (n=45)	Percent of total
Activities in which planning agencies should be involved:								
Advising public health agencies	46	88.5	33	82.5	58	86.6	37	82.2
Reviewing petitions for zoning amendments for health care facilities	45	86.5	29.	72.5	53	79.1	43	95.5
Advising private, voluntary organizations	44	84.6	35	87.5	53	79.1	36	80.0
Reviewing proposals for new health facilities	36	69.2	30	66.7	47	70.1	33	73.3
Preparing a section on health for the general plan	31	59.6	19	47.5	40	59.7	29	64.4
Making a comprehensive study of health facilities	14	26.9	14	35.0	31	46.3	15	33.3
Preparing site plans for medical centers	12	23.1	9	22.5	18	26.9	12	26.7
The attitudes of the agencies concerning their involvement in health care planning during the next few years:								
Our present level of involvement is adequate	9	17.3	8	20.0	7	10.4	6	13.3
We would like to play a more active role, but will not:								
Because of budgetary limitations	20	38.5	16	40.0	26	38.8	20	44.4
Because of lack of encouragement from the planning commission and city officials	5	9.6	7	17.5	13	19.4	6	13.6
Because the health organizations will discourage involvement	4	7.7	4	10.0	3	4.5	6	13.6
We have plans for expanding our role in this area[1]	15	28.8	9	22.5	19	28.4	6	13.3
No opinion	10	19.2	6	15.0	15	22.4	13	29.5

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[1] Examples of means of expansion include general plan studies, CRP studies, demonstration cities grants, zoning ordinance review, and the establishment of closer ties with health planning agencies.

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